MARKET STUDY FOR
HOME HEALTH CARE SERVICES

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EXECUTIVE SUMMARY

This report is part of a larger project funded by the Health Care Financing Administration to design competitive bidding systems that can be used by the Medicare and Medicaid programs to purchase home health services. The purpose of this study of the home health care market is to develop an understanding of its industrial structure, how agencies compete, and recent trends in expenditures and service patterns. This should assist in not only assessing the feasibility and attractiveness of competitive bidding strategies, but also in designing alternative systems that are most likely to achieve Medicare and or Medicaid objectives for home health care procurement.

This study focuses on the skilled home health care services covered under the Medicare program. Durable medical equipment, and homemaker and personal care type services not covered by Medicare are not included in the study. Consistent with this product definition, only Medicare-certified agencies are examined in this report.

The methodology used involved two primary tasks. Firstly, we reviewed data and information available at the national level on home health care market information and trends. Secondly, we conducted intensive market studies in three home health care market areas, Sacramento-Stockton, New Orleans and Boston. These

areas were selected for their geographic diversity and their diversity in home health care market characteristics. At each site, interviews were conducted with home health agency administrators, Medicare intermediary staff, Medicaid staff, hospital discharge planners, state regulatory personnel and others directly involved in the home health care industry.

The three market study sites differ with respect to size, demographics, region, medical care resources and other factors. They also differ with respect to several important characteristics of the market for home health services, while they are similar with respect to others. Brief summaries of the findings from the three market studies are provided below.

Sacramento-Stockton

Sacramento, California's state capital, has a metropolitan area population of 1.2 million. Stockton, which is 50 miles south of Sacramento, has a metropolitan area population of about 400,000. Sacramento/Stockton was chosen as a market study site partly to study home health service patterns in a moderate size city and in nearby smaller, but relatively independent cities. Four distinct geographic markets were identified in the Sacramento/Stockton area: the city of Sacramento, the city of Stockton and two smaller nearby cities. Sacramento and Stockton are served by different home health agencies. One of the smaller

cities is served by several branch offices of the Sacramento agencies while the other is served by two independent agencies.

The Sacramento/Stockton home health care markets have become increasingly competitive, with substantial growth in number of agencies, marketing activity and volume of business. In 1983, nine Medicare-certified agencies were active in Sacramento. In 1984, a total of seventeen were licensed, although only fourteen were determined to be active. The number of home health visits in Sacramento and Stockton increased by 129 percent between 1981 and 1983; on a per-capita basis for those age 65 and over, it increased from .47 to 1.02 visits.

The Sacramento home health market is highly concentrated, although less so than in the past. The largest agency, a Visiting Nurse Association (VNA), had a 60 percent share of Medicare volume in 1983, substantially less than two years earlier. The largest five agencies (one VNA and four proprietaries) had a combined 95 percent market share in 1983. As in each of the market study sites, the primary source of home health referrals was hospital discharge planners, with physicians a distant second. Perceived quality of service was cited as the primary selection criterion among hospital discharge planners; price plays little or no role as a selection criterion for Medicare, Medicaid and even private pay patients, according to referral sources and agencies interviewed.

Medicare represented about 90 percent of total patient visits, with Medicaid and private pay (private insurance and self-pay) accounting for the remainder. Medicare charges, which were reported to be used for all payors, tended to be close to the Medicare payment limits. Hospital-based agencies had the highest charge levels (Medicare payment limits are highest for hospital-based agencies) while proprietary agency charges tended to be somewhat higher than VNA charges. Medicaid payment rates were substantially below Medicare limits. Because of the low Medicaid payment rates, some agencies indicated that they and other agencies sometimes sought to avoid Medicaid patients.

Agency reaction to the prospect of competitive bidding was mixed. All of the agencies interviewed had been exposed to competitive bidding, although the bidding system sponsors (HMOs and PPOs) had miniscule market shares. While there was a consensus that competitive bidding could produce lower costs, several agencies expressed concern about the possibility of poor quality service under the system. There was considerable concern about quality in a single winning bidder system, under which there would be no continuing competition among agencies on the basis of quality and adequacy of service.

New Orleans

The New Orleans metropolitan area is geographically unique in that portions of it are separated up to 26 miles by Lake

Pontchartrain and by the Mississippi River. The metropolitan area has a population of 1.3 million persons. The New Orleans economy is relatively poor. It has higher than average unemployment, and a large portion of the population (26 percent in 1983) is below the poverty level, more than twice that of the country as a whole.

Home health agencies in Louisiana are only minimally regulated. State-required qualifications and experience of home health care personnel are minimal, much less so than in California and Massachusetts. State licensure requirements and minimal standards are now being revised.

Three distinct geographically defined home health agency markets have been identified: New Orleans proper, and smaller markets on the west bank of the Mississippi River and on the north side of Lake Pontchartrain. With one or two exceptions, all of the agencies actually serving the latter two markets are based in those localities, although some other agencies based in New Orleans said they would serve these outlying areas if requested.

As in Sacramento, home health care business and the number of agencies are each expanding very rapidly. Between 1981 and 1983, Medicare home health visits increased 109 percent; for those age 65 and over, it increased from .69 to 1.38 visits per capita. In 1983, there were 14 active Medicare-certified

agencies in the New Orleans metropolitan area. The number of agencies had increased to approximately 40 in September, 1984.

Market concentration was less in New Orleans than in Sacramento, with the largest agency accounting for 21 percent of 1983 Medicare charges. The combined market share of the largest five was 69 percent. Of these agencies, four were proprietary and one was hospital-based. Medicare volume accounted for approximately 95 percent of agency volume, with the exception of two government agencies which treated primarily indigent (no-pay) and Medicaid patients. Private pay business is minimal in New Orleans, accounting for 2 to 5 percent of agency volume according to the agencies interviewed.

Home health agencies compete for referrals, primarily from hospital discharge planners and other hospital staff who are estimated to account for 75 percent of all patients. Increasingly, agencies are marketing to physicians. Provision of quality services was cited by both agencies and referral sources as the most important factor in attracting and maintaining a sizeable market share. Prompt response to requests for service and 24 hour on-call capability were also identified as important competitive features. Price was reported to play no role in competition among agencies.

Medicare charges varied considerably among agencies (charges based on costs were high for newer agencies with high

start-up costs and little volume) but on average were close to the Medicare limits. Louisiana Medicaid uses the same payment limits as Medicare.

Agency reaction to competitive bidding was negative. Firstly, agencies had little or no exposure to competitive bidding and had some initial difficulty in grasping the concept. Views were expressed that under competitive bidding, most smaller and newer agencies would be driven out of the market, the system would not work, local physicians would not tolerate it, selection of winning agencies would be based on graft and kickbacks, and quality of service would deteriorate. Several agencies expressed the view that in the short run costs may be reduced, but that in the long run costs would rise because competition would diminish as many agencies would be forced out of business.

Boston

The Boston metropolitan area incorporates a semi-circular area of 1,237 square miles. With a population of 3.7 million, it is the largest of the market study cities and has the highest population density. The central city (Boston, proper) is surrounded by numerous smaller cities and towns. Every portion of the Boston metropolitan area is identified as part of a particular city or town, an important fact for determining market definition for the traditional VNA agencies which are township-based.

There is a long tradition of town responsibility for local welfare that has led to the establishment and to local philanthropic support for VNAs. Proprietary agencies could not be Medicare-certified in Massachusetts until recently. This fact, along with the long history of VNAs being the primary home health providers, explain why VNAs continue to dominate the market.

Proprietary agencies tend to define their market as the entire metropolitan area, and some VNAs have expanded beyond their traditional service areas. However, geographic markets are still best defined by township and other political boundaries, within which a local VNA is dominant.

The volume of home health visits is expanding less rapidly in Boston than in Sacramento/Stockton and New Orleans, although from a higher base. Medicare visits increased 62 percent between 1981 and 1983. On a per capita basis for those age 65 and over, visits increased 55 percent, to 2.21 in 1983. This was 60 percent and 1.7 percent, respectively, above visit levels in New Orleans and Sacramento/Stockton. The higher utilization in Boston may be related to the long tradition of locally supported social services and the existence of VNAs in most localities.

There were 48 active Medicare-certified agencies in 1983 in the Boston area. As of June 30, 1984, this had increased to 60. Of the 60, 30 were VNAs, 10 were proprietary agencies, 8

were hospital-based agencies and the remainder were government and other non-proprietary type agencies. Most of the newer agencies were either proprietary or hospital-based.

The largest home health agency has a 28 percent share of the Boston metropolitan area market. Each of the five largest agencies is a VNA, with a combined market share of 48 percent. While on the surface, this suggests a lower market concentration in Boston than in the other market study cities, this is not the case. Within the local narrowly defined market areas, the local VNA typically has more than half of the market and in some cases as much as 95 percent of the market.

Medicaid and private pay volume is larger in Boston relative to Medicare volume than in the other market study sites. Based on the limited data that were available and on information provided by agencies, it is estimated that the Medicaid and private pay shares of home health revenues are 15-25 percent and 5-15 percent, respectively.

Medicare charge levels are substantially below Medicare limits in Boston (and below agency charges in Sacramento and New Orleans), especially for the VNAs, which provide most of the home health care in Boston. Medicaid payment rates, based on costs but further limited by other factors, are approximately half of the Medicare limits.

As in the other market study sites, most referrals come from hospital discharge planners. Based on discussions with discharge planners and agencies, the most important factors responsible for referrals to specific agencies are quality, prompt accessibility of required services and longstanding relationships with specific agencies, generally VNAs. Proprietary agencies complained about hospital favoritism toward VNAs and their inability to obtain referrals from hospital discharge planners.

Reactions by agencies to the prospect of competitive bidding were mixed. Most believed that the number of agencies in the area would decline, and this would result in short term savings. Agencies differed on prospects for long term cost reductions. As in Sacramento and New Orleans, much concern was expressed about possible deterioration of quality under competitive bidding.

Primary Study Conclusions

Based on the three market studies and information obtained from HCFA and other sources, a number of primary study conclusions were developed.

- Home health care services represent a small but rapidly growing share of total health expenditures. Home health care expenditures have been estimated

at $2.6 billion in 1983, of which 60-70 percent is paid by Medicare and an additional 20-25 percent by Medicaid. Medicare home health expenditures have been growing at an average annual rate of 30 percent per year since 1974, and will continue to grow more rapidly than other health care expenditure categories. The primary factors responsible for this continuing rapid growth are growth in the aged population, increasing preference for home over inpatient care and third-party payor efforts to substitute home care for inpatient hospital and nursing home care.

- The geographic market for home health care services in metropolitan areas is typically the entire metropolitan area, and may include nearby less populated areas. For hospital-based agencies and VNAs in some areas, the market may be more narrowly defined.

- Most large cities now have a large and growing number of home health agencies. Home health care markets are becoming increasingly competitive. Between December 1982 and December 1984, the number of Medicare-certified agencies increased from 3,639 to 5,274, an increase of 45 percent.

- The distribution of agencies by agency type is changing. While VNAs retain the largest market share, they are declining in relative importance, while proprietary, private non-profit and hospital-based agencies are increasing in importance. In 1972, hospital-based and proprietary agencies represented 12 percent of all agencies. In 1984, they represented 47 percent of all agencies.

- Barriers to market entry for home health agencies are minimal. Capital and regulatory requirements are not substantial. As noted, between December 1982 and December 1984, the number of Medicare-certified agencies increased by 45 percent. Growth in the number of agencies is expected to continue through 1985.

- Competition by agencies is primarily for sources of referral, rather than directly for the consumer. The most important referral sources are hospital discharge planners and other hospital staff (60-75 percent), followed distantly by physicians (10-20 percent) and patients' family and friends (5-15 percent). Primary agency selection criteria are quality, reliability, range of services, and

availability of services on short notice. Price plays almost no role.

- Agency costs and charges varied by individual agency but appear to be strongly influenced by Medicare payment limits. In two of the three market sites, agency charges tended to be very close to Medicare payment limits. Discussions with agencies suggest that the existing Medicare cost reimbursement methodology encourages agencies to structure their costs to be at or near Medicare payment limits.

In addition to seeking to determine characteristics of the home health care market, we sought to draw implications from the study findings for possible Medicare and/or Medicaid use of competitive bidding. They are stated briefly below.

1. Growing competitiveness of markets. Home health care agencies are becoming more numerous and more aggressively competitive. Competitive providers who are actively seeking business are more likely to respond positively to and submit attractive bids than less competitive providers. The more competitive environment enhances prospects for success of competitive bidding.

2. Concerns about quality. The prospect of reduced quality was the major concern expressed about competitive bidding. Concerns were raised about price being the sole or primary selection criterion, of low bidders not being able to adequately provide increased volume of services, and of quality and patient visit time being reduced under the system. Clearly, assuring adequate levels of quality and service under the competitive bidding program needs to be a primary objective, both in designing and in administering the program.

3. Medicare accounts for most agency revenue. In the aggregate, Medicare accounts for 60 to 70 percent of home health agency revenue, with Medicaid accounting for much of the rest. If a sizeable share of agency revenue comes from private payers, HCFA could be less concerned about the impact of its system on the industry and on access to care of private patients. However, because of its dominance, HCFA does have to be concerned about the effects of its action on possible growth of monopoly power, and on costs and access to use of others.

4. Medicare limits do not accurately reflect required resource costs of providing services. There are indications, based on cost variability among agencies

and on comments received from agencies, that Medicare cost limits do not accurately reflect the necessary costs of efficiently providing different home health care services. This suggests that prices and relative bid prices among types of services under competitive bidding may be substantially different from those which exist under the current Medicare cost reimbursement system.

5. Cost reimbursement provides poor incentives and results in high administrative costs. Several agencies freely admitted that they (like others) seek, through cost allocation between allied businesses and adjustment of administrative costs, to achieve reported cost levels that are close to the Medicare limits in order to maximize revenue. In addition, many agencies complained about substantial administrative costs related to preparing and securing intermediary approval of cost reports. A simpler system embodying incentives for cost-effective provision of services could result in substantial savings.

6. Substantial returns to scale do not exist. While most agencies could not accurately describe the relationship between average visit cost and volume, most indicated that direct labor cost was the primary

agency cost, and that fixed cost tended to be relatively low. Some economies may be achieved if increased volume reduces average travel time. However, cost reductions are not likely to be significantly different where a single agency provides all home health care in a metropolitan area or a small number of agencies (e.g., three to five) provide the care.

The implications from these market studies, particularly from the information received from the agencies themselves, suggests that substantial program savings could result under a well designed competitive bidding system. But serious, legitimate concerns exist about quality, adequacy of service and monopoly. They need to be seriously addressed in the design and administration of the systems.

1. INTRODUCTION

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1.1 Purpose of the Study

Most of the economic and market research that has been done on the home health care industry has focused on Medicare and Medicaid program interactions with the home health industry, as a whole. Studies sponsored by the federal government and various state governments have compared payment levels across states, and examined growth in Medicare and Medicaid payments, numbers of visits, costs per visit and payments by type of provider. However, little is known about characteristics of the home health market that do not directly relate to the Medicare and Medicaid programs. If these programs wish to move to payment approaches which rely on competitive market forces, it is necessary to first know the shape of those markets, the issues on which they compete and how they are likely to be affected by competitive bidding. In other words, there is a need for an industrial organization type approach to the study of the industry. To date, we are not aware of the existence of any such studies in home health.

1.1.1 Study Objectives

In developing competitive bidding models for home health agencies, it is useful to have an accurate and current picture of the market and the extent and nature of competition in home health care. While our earlier literature review has described

and assessed various bidding models and how they have been applied in the health care delivery system, this report focuses on the particular market into which competitive approaches might be introduced.

To gain this perspective, the Center for Health Policy Studies conducted limited studies of the market for home health care services in three areas. These studies dealt primarily with the economic characteristics of home health care and characteristics of the services and service providers. Specifically, in each of the market areas we sought answers to the following questions:

- What is the size of the market?
- What are the geographical dimensions of the market?
- What is the organizational structure of the market?
- What are the roles of the various types of home health agencies in the market?
- What are the primary components of agency costs?
- How does cost vary with volume of services?
- Do market shares differ for Medicare, Medicaid and private payor work?
- On what basis do home health agencies compete for business?
- What are the usual staffing patterns of agencies?

- What are the prevailing prices and payment levels for home health services?
- How do differences in payment levels affect agencies selecting or avoiding particular classes of patients?
- What is the range of services offered by agencies?
- What features about the Medicare and Medicaid programs do agencies find burdensome or problematic?

1.1.2 Limitations of the Study

The intent in conducting the three limited market studies was not to prepare a single, comprehensive industrial organization study of the home health care industry; rather, it was to develop information, data, and an understanding of the industry which will be useful in designing a competitive bidding system.

It is important to note that this document is intended to be a background piece only. The home health care industry in a given market area has numerous participants, each with different interests and different perspectives. Interviews were conducted with a limited number of Medicare-certified agencies, third-party payors, state government officials, and referral agents in each area. The information derived from individual interviews and reported in this study reflect the perspectives and biases of those interviewed and may not necessarily accurately reflect conditions in specific market areas or be typical of other market areas. In regard to several important issues, conflicting views

were expressed. The reader is cautioned against drawing precise generalizations from such a small interview sample. In an effort to mitigate this limitation, and to provide a larger framework in which to assess the market studies, we have provided a review of the overall home health care industry, its services and its participants.

We have attempted to present a diversity of perspectives and believe that a fair degree of balance has been achieved. We believe that the primary conclusions reached and reported in the final chapter of this report are valid. This report, along with associated data and information collected while conducting these studies, should not be viewed as ends in themselves, but rather as inputs into the overall project effort, designed to help produce a superior bidding system. Many of the issues raised in the course of this report, such as quality of home health services and market restriction under a competitive bidding system, will be dealt with at length in later reports to be delivered under this contract.

1.2 Background - A National Perspective

In order to assess prospects for Medicare and/or Medicaid competitive bidding for home health services, and to design systems that will be likely to meet program objectives, it is

important to understand the recent trends in the home health care industry, and the nature of the current market for home health services. Current trends in supply and demand for home health services can best be viewed at a national level, which also provides a context for more micro-level analysis of provider and consumer behavior in local home health markets.

This section sets out the dimensions of the national market for home health services. The first issue considered is the definition of the product that is exchanged in this market, i.e., definitions of home health services purchased by various payors. The remainder of the section describes the market actors, including patients, referral agents, providers, and payors. Special attention is paid to the impact of Medicare on price and quantity of home health services provided to its beneficiaries.

1.2.1 Home Health Care: The Product

In the broadest sense, home health care might be defined as care provided to patients in their homes, required because of adverse health conditions. However, more restrictive definitions are used to specify home health care services covered by public and private insurance, and these definitions, in turn, define the services supplied by most home health agencies.

Medicare Home Health Services Definition.

Medicare home health care services are defined both by the recipient patients, who must be Medicare-eligible and in need of skilled care for recovery and rehabilitation after an acute illness episode; and by the agencies and professions that provide the service.

Home health care services covered by Medicare include:

1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

2) physical, occupational, and speech therapy;

3) medical social services under the direction of a physician;

4) home health aide services primarily provided to assist with the patient's personal care, under the supervision of a registered nurse; and

5) medical appliances and supplies (other than drugs and biologicals).

Services are provided only to Medicare-eligible individuals

requiring skilled care and are aimed at rehabilitation rather than provision of continuing in-home support. To be eligible for home health services under Medicare, a person must be homebound, under a physician's care, and in need of part-time or intermittent skilled nursing care and/or physical or speech therapy[1]. Care must be prescribed by a physician and provided by a Medicare-certified home health agency (either directly or through arrangements with others) in accordance with the physician's treatment plan.

To receive Medicare home health services, a patient must be enrolled in Part A, which is automatic for most Americans age 65 and over, or Part B, Supplemental Medical Insurance. Enrollment in Part B is voluntary, requires payment of a premium, and is available to persons age 65 or older or those eligible for Part A. Part B can cover Medicare home health services for enrolled individuals not covered by Part A. Approximately 95 percent of those enrolled in Part A also participate in Part B. In 1982, 98.3 percent of all reimbursements for Medicare home health services were made under Part A.

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[1]The Omnibus Budget Reconciliation Act (OBRA) of 1980 permitted persons to qualify for Medicare coverage based solely on the need for occupational therapy. Occupational therapy was eliminated as a qualifying service by the Omnibus Budget Reconciliation Act (OBRA)of 1981, effective December 31, 1983.

Until passage of the Omnibus Budget Reconciliation Act (OBRA) of 1980 (P.L. 96-499), several restrictions and limitations existed on the use of home health services. Medicare Part A provided home health coverage only to those individuals with a prior three-day stay in a hospital or a stay of any duration in a skilled nursing facility (SNF) where at least one day was paid by Medicare. The need for home health care had to be related to the illness for which the person received inpatient services. A plan for home health care had to be established by a physician within two weeks of discharge from the institution, and coverage was restricted to 100 visits during the year following discharge from the hospital or SNF.

Part B coverage for home health services was extended only to those individuals who did not have a prior institutionalization or had exhausted their Part A coverage. Reimbursement was restricted to 100 visits in any calendar year. Beneficiaries under Part B were required to satisfy an annual deductible of $60, and until passage of the recent Social Security Amendments, pay a 20 percent coinsurance on home health services.

OBRA 1980 eliminated the 100 visit limit under both Parts A and B; the three day prior hospitalization requirement under Part A; and the $60 deductible under Part B (for home services only). The act also eliminated the requirement that proprietary home health agencies could participate in Medicare only if they were licensed by states that had licensure laws for proprietary

agencies. (Only 27 states had such laws in 1981 [Inspector General's Report, 1981].)

It should be noted that a sizeable proportion of home health agencies are not Medicare-certified. These agencies are not eligible for Medicare reimbursement. Most of these agencies provide homemaker and companion type services, which are not covered by Medicare, while some provide skilled home health services as well.

Medicaid Home Health Services Definition.

Home health coverage was made available to the Medicaid categorically needy (usually persons receiving cash assistance under AFDC or SSI) in 1970. State Medicaid plans must cover home health services for all categorically needy individuals aged 21 years and older (and those under 21 if the plan offers them skilled nursing facilities), as well as medically needy persons (persons who have enough income and resources to pay for their basic living expenses, but not enough to pay for their medical care) eligible under the Plan for skilled nursing facility services. As with Medicare, the recipient's physician must write a care plan authorizing home care services and review the plan every 60 days.

At a minimum, the states must offer the following services in their home health packages:

a) part-time or intermittent skilled nursing services;

b) home health aide services;

c) medical supplies, equipment, and appliances suitable for use in the home.

Optional services that the states may choose to be included in home health care benefits are physical therapy, occupational therapy, speech therapy and audiology.

In general, Medicaid services are provided by agencies that meet the requirements for Medicare certification. This is often because both programs use the same certifying body.

In addition to the mandated and optional services mentioned above, states are permitted to include in their Medicaid programs, services that are not included in the strict definition of home health services. States may apply to the federal government to provide an even broader range of home care services to all Medicaid eligibles or selected target groups. Section 2176 of the Omnibus Budget Reconciliation Act of 1981 (P.L.97-35) granted the Secretary of Health and Human Services the authority to waive existing statutory requirements in order to permit states to finance, through the Medicaid Program, non-institutional long-term care services. Only services for Medicaid-eligible individuals who would otherwise require

placement in a skilled nursing facility, intermediate care facility or intermediate care facility for the mentally retarded can be covered under the Section 2176 waiver program.

The intent of the waivers was to give states greater flexibility in developing home and community-based delivery systems where they would serve as a more cost-effective alternative to nursing home care. The federal statute specifies six services that states may offer under their waiver programs: case management, homemaker/home health aide, personal care, adult day health care, habilitation and respite care. In addition, states may offer other services approved by the Department of Health and Human Services so long as they are necessary to avoid institutionalization and are cost-effective. These services may or may not be provided by Medicare-certified home health agencies.

As of July 1984, 47 states had submitted 138 waiver applications. Seventy-six waivers from 44 states have been approved. A review of 26 states whose waivers were approved before February 15, 1983, reveals the following:

1. The groups that are often targeted for the waiver are aged and physically disabled.

2. Twenty-four of the 26 states requested benefits for case management, 16 homemaker services,

8 home health aide, 11 personal care, 16 adult day health care services, 15 rehabilitation services, and 17 respite care. In addition, 20 states requested one or more "other" services - the most frequent one being transportation.

3. More than one-third of the programs for the aged/disabled used information pertaining to social and environmental factors as part of level of care determination.

Definitions Used by Other Payors.

Home health care benefits are provided under many private health insurance and health maintenance organization programs. Many private insurers that provide a home health benefit define covered home care more broadly than do Medicare or Medicaid. While requiring that a patient be in need of skilled care, other restrictions, such as those related to extent of service, are sometimes more relaxed allowing for services of a more continuous nature, including chronic skilled nursing and therapy. At the same time, however, total length of treatment may be limited by a visit maximum (e.g., 50 visits). Additional services available under a relatively small proportion of insurance policies and to all self-pay patients are of a less skilled nature, including chronic personal care and assistance with activities of daily living, homemaker, companion and respite care (services that are

not covered under Medicare). In some states, these less skilled home care services are paid for by special state funds or Title XX of the Social Security Act, or Title III of the Older Americans Act.

1.2.2 Market Participants

The participants in the market for home health services are the users of care, the patients; those that act as referral agents for home health services, primarily physicians and hospital discharge planners; the suppliers of care, the home health agencies; and the payors for home health care, most prominently the Medicare program, but also including Medicaid and other third party payors. Data on non-Medicare portions of the home health market are extremely limited. Therefore, this description of market participants focuses primarily on the Medicare home health segment of the market, which represents the overwhelming share of the market.

Patients.

The number of patients receiving home health care under Medicare and Medicaid has been growing rapidly (Exhibit 1-1). The number of Medicare home health users has increased 198 percent since 1974. It is interesting to note that the number of Medicaid users per 1000 recipients increased sharply between 1974 and 1975, but has been basically stable since 1975, while the

EXHIBIT 1-1

NUMBERS OF PERSONS RECEIVING
MEDICARE AND MEDICAID HOME HEALTH SERVICES

	Medicare		Medicaid	
Year	Number of Users (000s)	Per 1000 Enrollees	Number of Users (000s)	Per 1000 Recipients
1974	392.7	16.5	144	6.7
1975	499.6	20.2	343	15.6
1976	588.7	22.9	319	14.0
1977	689.7	26.1	371	16.3
1978	769.7	28.3	376	17.2
1979	836.7	30.0	359	16.7
1980	957.4	33.6	392	18.1
1981	1054.7	35.2	401	18.2
1982	1171.9	39.7	377	17.5

Sources: HCFA, Health Care Financing Program Statistics, "Medicare Use of Home Health Services," Series; The Medicare and Medicaid Data Book 1981 and 1983.

home health rate of use under Medicare continues to increase. The relatively high rate of Medicaid recipients' usage of home health services is due in part to inclusion of usage for those with joint Medicare-Medicaid eligibility.

Older people are much more likely to use home health services than are their younger counterparts, because of their physical disabilities, their family situations, and coverage of some home health care by the Medicare program. At the time of the Health Interview Survey (HIS) in 1979 (Barbara A. Feller, "Americans Needing Help to Function at Home," National Center for Health Statistics Advance Data, September 14, 1983), 619,000 persons 65 years of age or older were receiving some type of nursing or medical care at home. The rate of use for those 65 to 74 was 14.8 per 1000 persons, while those 75 and over experienced a rate of use of 47.3 per thousand. This may be compared to a rate of use for the population 18 to 64 of 5.3 per thousand.

The HIS home health use rates for persons 65 years and older are lower than Medicare use rates because the HIS study measured use at a specific point in time, while Medicare data would reflect home health use at any point during the program year. The HIS data show the strong relationship between home health care use and age. The study findings strongly suggest that the continuing aging of the nation's population, with growth of almost 3 percent per year in the number of those aged 65 and over, and an even more rapidly increasing number and proportion

of those 75 and over, would be expected to increase demand for health services at home.

The average number of visits per user has increased, although less rapidly than the number of users. As shown in Exhibit 1-2, average number of visits increased from 1974 to 1976, (20.6 to 22.7), remained relatively stable from 1976 to 1979 (22.7 to 22.9), and increased substantially from 1979 to 1982 (22.9 to 26.3).

Data on the average number of visits for persons receiving a specific type of visit are shown in Exhibit 1-3A. Between 1974 and 1980, there is very little change for each of the four types of visits shown. Exhibit 1-3b shows the average number of visits for all persons receiving any type of visit for 1974 and 1980. Nursing visits per person receiving any type of visit declined, while home health aide and physical therapy visits increased. The data in Exhibits 1-3a and 1-3b, considered together, show that there has been a shift among home health care users, towards increased use of home health aide and physical therapy services.

Referral Agents.

Under Medicare, Medicaid and private insurance, in order for home health services to be covered, the treatment must be prescribed by a physician. In fact, however, it is usually a

EXHIBIT 1-2

AVERAGE NUMBER OF MEDICARE HOME HEALTH VISITS PER USER

YEAR	VISITS PER PERSONS SERVED
1974	20.6
1975	21.6
1976	22.7
1977	22.5
1978	22.5
1979	22.9
1980	23.4
1981	25.0
1982	26.3

Source: HCFA/Bureau of Data Management and Strategy

EXHIBIT 1-3A

NUMBER OF VISITS PER PERSON RECEIVING EACH VISIT TYPE, 1974-1980

Type of Visit	1974	1980	Annual Compounded Rate of Growth (%)
TOTAL	20.6	23.4	2.2
Nursing Care	13.9	13.0	-1.1
Home Health Aide	19.7	20.8	0.9
Physical Therapy	10.4	10.2	-0.3
Other[1]	6.9	6.7	-0.5

EXHIBIT 1-3B

NUMBER OF VISITS PER ALL PERSONS SERVED BY VISIT TYPE, 1974-1980

Type of Visit	1974	1980	Annual Compounded Rate of Growth (%)
ALL	20.6	23.4	2.1
Nursing Care	13.3	12.4	- 1.2
Home Health Aide	4.8	7.5	7.4
Physical Therapy	2.0	2.6	4.4
Other[1]	0.5	0.9	9.8

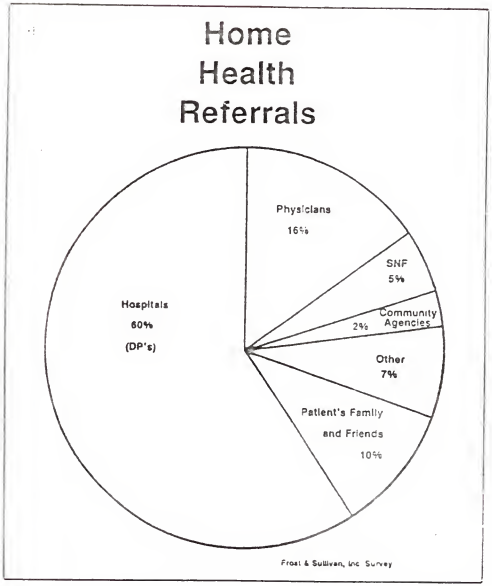
[1]Includes speech or occupational therapy, medical social services and other health disciplines.

Source: Bishop and Stassen, 1983.

hospital discharge planner who arranges for home health services for a discharged patient. This is shown in Exhibit 1-4. Based on a recent survey conducted by Frost and Sullivan, Inc., 60 percent of referrals come from hospital discharge planners, 16 percent from physicians and the remainder from other sources. According to a recent article in Hospitals (November 16, 1984), the role of discharge planning in hospitals has increased since the introduction of PPS, as planners are pressured by hospital staff to move patients out as quickly as possible. Persons doing discharge planning include social workers within the hospital social service department, nurses in continuing care departments, and, in a few instances, individual primary nurses taking after-care responsibility for patients assigned to them for in-hospital care. Families, friends and disabled individuals themselves also occasionally seek home health care. Referrals from other institutions, e.g., nursing homes, are rare.

Home Health Agencies.

Home health agencies can be described by type of agency, scale of operation (annual volume of visits or revenues), scope of services offered, type of patients served, and degree of reliance on various types of payors for reimbursement. Location by region and whether urban or rural is also of interest, and patterns of service delivery in particular market areas could be especially important in assessing potential market segmentation and local monopoly under competitive bidding.


Home
Health
Referrals
Physicians
16%
SNF
5%
Community
Agencies
2%
Other
7%
Patient's Family
and Friends
10%
Hospitals
60%
(DP's)
Frost & Sullivan, Inc Survey

As would be expected, the substantial recent increases in demand for home health services has been met by home health agencies through a combination of increase in size of existing agencies and entry of new suppliers. Exhibit 1-5 shows that the number of Medicare-certified agencies grew over 65 percent between 1972 and 1982, an average annual rate of 5.1 percent. Between 1982 and 1984, the number of agencies grew at a considerably more rapid rate, 20.1 percent per year. New entrants were most likely to be for-profit, private non-profit, or facility-based rather than traditional VNA and public agencies. Although the numbers of agencies in these latter categories have declined only slightly between 1972 and 1984, their share of the total number of agencies has fallen markedly (83 percent in 1972, versus 34 percent in 1984).

The rapid growth in the number of agencies over the past two years, from 3,639 in 1982 to 5,274 in 1984, has resulted in increased competition in many markets. However, one factor that may change the nature of competition, is the growth in hospital-based agencies. According to a survey of 450 hospital administrators conducted by National Research Corporation (NRC), 25 percent of all hospitals were offering home health care services in 1983 (Modern Healthcare, December 1984). In 1984, this had increased to 42 percent or more than 2,000 hospitals. The survey also found that 60 percent of all hospitals of 300 beds or more provided home care services in 1984. Data in Exhibit 1-5 show the number of hospital-based agencies increasing

Medicare Certified Home Health Agencies
by Auspices

1972 and 1982 - 84

Type of Ownership	1972[1]		1982[1]		1983[1]		1984[1]		Average Annual Rate of Change	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	72-82	82-84
VNA	531	24.0	517	14.2	520	12.2	525	10.0	-0.3	0.7
Combined Voluntary/ Government	55	2.5	59	1.6	58	1.4	59	1.1	0.7[3]	0.0[3]
Government	1255	56.7	1211	33.3	1230	28.9	1226	23.2	-0.3	0.6
Rehabilitation Facility-Based	11	0.5	16	0.4	19	0.4	22	0.4	3.8[2]	17.3[2]
Hospital-Based	231	10.4	507	13.9	579	13.6	894	17.0	8.2	32.8
SNF-Based	7	0.3	32	0.9	136	3.2	175	3.3	16.4[2]	233.9[2]
Proprietary	43	1.9	628	17.3	997	23.4	1596	30.3	30.8[3]	59.4
Private Non-Profit & Other	79	3.6	669	18.4	719	16.9	777	14.7	22.3[3]	7.7
TOTAL	2212	100.0	3639	100.0	4258	100.0	5274	100.0	5.1	20.1

Source: [1]HCFA/Health Standards and Quality Bureau; as of December 31 of each year.
[2]Base number is less than one percent of total agencies.
[3]Base number is less than five percent of total agencies.

from 507 to 894 between 1982 and 1984. However, these figures may understate the true growth in hospital "affiliated" agencies because parent corporations of some hospitals are operating home health agencies as separate for-profit subsidiaries. These agencies would not be categorized as hospital-based but as proprietary in the HCFA data shown in Exhibit 1-5. Other possible reasons for the discrepancy in hospital-based or affiliated agencies are that some of the newer hospital-based agencies may not yet be certified and some agencies are not Medicare-certified because they provide only specialized services which are not covered by Medicare.

A survey of hospital administrators focused on projected areas of hospital expansion (Hospitals, January 1, 1985). Seventy-six percent of hospital administrators indicated that they plan to add or expand home health services: a greater proportion than for any other of the services mentioned. The recent rapid growth in hospital-based agencies at the projected continuing rapid growth may change the competitive character of the market in many areas. As hospital discharge planners and other hospital personnel are responsible for most home health referrals, an increasing number of hospitals may be channelling patients primarily to their own agencies. In areas where most hospitals operate their own agencies, this could cause further erosion in the share of the market held by VNAs as well as prevent unaffiliated proprietary agencies from achieving significant market shares.

Another significant development in the industry is the growth of home health "chains". Chains are groups of two or more home health agencies that are owned, leased or controlled by a single organization. Some chains operate within only a single state, while others are national corporations and provide Medicare services in multiple states. This puts them in an advantageous position to compete for business with multi-state, self-insured corporations and insurance companies. In 1983, there were 83 Medicare-recognized chains (including government chains) representing 545 agencies. In 1984, the number of chains grew to 89, while the number of chain operated agencies grew to 721, an increase of 32 percent. According to Medicare sources, the five largest chains were Beverly Home Health Services, Upjohn Healthcare Services, Kimberly Services, Medical Personnel Pool and Kelly Health Care. These five corporations had 339 home health agencies among them in 1984. One of these home health chains grew from 31 to 134 Medicare-certified agencies in that one year. It is further important to note that many corporations have other home care service operations that are either not Medicare-certified or provide care to the private side only.

Along with the increase in numbers of certain types of agencies has came an increase in the number of Medicare patients served by them. Changes between 1974 and 1982, in persons served by agency type are shown in Exhibit 1-6. VNAs and government-based agencies are serving a shrinking proportion of Medicare cases, while proprietary and hospital-based agencies are

expanding their case loads more rapidly than average. In 1974, VNAs and government related agencies saw 76 percent of the Medicare home health users; by 1982, this proportion dropped to 55 percent. At the same time, hospital-based and proprietary agencies expanded from serving 15 percent of Medicare home health users to 24 percent. Private non-profit agencies originally arose in response to HCFA's licensing constraints on proprietary agencies, but fell after the restriction was removed. Thus, the expansion of supply has been accompanied by changes in the configuration of the home health industry, by ownership and scale, and other characteristics.

In the case of each agency type, the response to general demand expansion was enhanced by special factors. Proprietary providers entered the market, as would be expected, to capitalize on expanding home health demand, but initially could not participate in Medicare in states that did not license for-profit home health providers. Private non-profit agencies were set up to meet this condition, and to satisfy perceived community preference for service delivery by non-profits. Many observers, however, saw them as differing little from explicitly for-profit providers. Changes introduced by the OBRA 1980 allowed proprietary agencies to participate directly in Medicare even in states in which proprietaries were not licensed. Thus, the growth of the private non-profit agencies is expected to slow while the growth of the proprietaries increases.

NUMBER OF MEDICARE BENEFICIARIES
SERVED BY TYPE OF AGENCY
(000's)

Agency Type	1974 Number of Persons	1974 Percent	1980 Number of Persons	1980 Percent	1982 Number of Persons	1982 Percent
VNA	189.0	48.1	376.9	39.4	431.9	36.9
Combined Government/ Voluntary	18.4	4.7	16.2	1.7	17.9	1.5
Government	90.0	22.9	173.5	18.1	197.6	16.9
Hospital-Based	47.0	12.0	113.8	11.9	155.1	13.2
Proprietary	12.0	3.1	61.7	6.4	124.4	10.6
Private Non-Profit and Other	36.4	9.3	215.3	22.5	244.9	20.9
TOTAL	392.7	100.0	957.4	100.0	1171.8	100.0

Source: HCFA Notes: Participating Providers and Suppliers of Health Service, 1981, HCFA, Office of Research and Demonstrations; HCFA Publication Number 03161, September 1983.

Hospital-based agencies may have been encouraged to a limited extent by the establishment of an add-on to cost limits for Medicare home health reimbursement, even though the so-called dual limits no longer exist. More important and as noted earlier, most patients are referred to home health care by hospital staff after discharge. Hospitals, therefore, have ready access to patients in need of care. In addition, under Medicare's Prospective Payment System for hospitals, direct provision of home health care by hospitals should become more attractive, since a hospital-based agency can allow a hospital to shorten fixed-reimbursement, in-patient stays while capturing additional cost-based home health payments.

Exhibits 1-7, 1-8, 1-9, and 1-10 highlight various characteristics of agencies by type of agency. Exhibit 1-7 shows the distribution of agencies by type and by region. It demonstrates that different types of agencies are more common in some regions than others. VNAs have been the mainstay of the home health industry in New England, where they have been, and continue to be, a full two-thirds of the agencies in that region. In the Middle Atlantic region, a third of the agencies are VNAs but government and hospital-based agencies are equally represented. Government-sponsored agencies are more common in the Central regions of the country, where they make up about two-thirds of the agencies. In the Pacific and South Atlantic regions, where both the general population and the proportion of elderly have been growing, proprietaries and private non-profit agencies have

EXHIBIT 1-7

Distribution of Medicare Certified Home Health Agencies by Agency Type
Within Geographic Division, 1974 and 1980

	All Agencies		Visiting Nurse Associations		Combined Gov't. & Voluntary		Government		Hospital Based		Proprietary, PNP, Other	
	1974	1980	1974	1980	1974	1980	1974	1980	1974	1980	1974	1980
United States	2,329 (100.0%)	2,829 (100.0%)	22.8	18.0	2.2	1.8	55.7	44.9	11.6	12.2	7.6	23.1
New England	343 (100.0%)	317 (100.0%)	69.4	66.9	2.6	1.0	19.8	17.0	7.3	6.6	0.9	8.5
Middle Atlantic	282 (100.0%)	281 (100.0%)	32.9	32.7	1.7	1.8	31.9	26.3	30.5	28.5	2.8	10.7
East North Central	335 (100.0)	433 (100.0)	25.7	19.6	3.3	2.5	56.4	47.3	9.8	11.1	4.8	19.4
West North Central	244 (100.0%)	345 (100.0%)	10.2	5.8	2.0	3.2	71.3	69.6	15.2	13.6	1.2	7.8
South Atlantic	338 (100.0%)	404 (100.0%)	7.9	9.9	3.6	1.7	73.9	38.9	5.9	7.4	8.6	42.1
East South Central	298 (100.0%)	410 (100.0%)	3.0	2.2	0.0	1.2	85.2	64.4	7.4	8.8	4.4	23.4
West South Central	254 (100.0%)	305 (100.0%)	4.3	3.6	0.0	0.0	70.1	56.1	2.7	4.6	22.4	34.8
Mountain	91 (100.0%)	127 (100.0%)	13.2	7.9	5.5	3.9	56.0	52.8	14.3	18.1	10.9	17.3
Pacific	144 (100.0%)	207 (100.0%)	21.5	14.9	2.8	0.0	30.6	19.3	18.0	21.7	27.1	43.9

Source: Health Care Financing Administration, unpublished statistics.

moved in to fill patient demand. While they made up only about a quarter of all agencies in the entire country in 1980, they were 40 and 42 percent of the agencies in those regions. Since 1980, proprietaries have become more numerous in all regions.

Exhibit 1-8 further points out the differences in agency distribution. It shows that a disproportionate 40 percent of all the VNAs in the U.S. are found in New England, while the sun-belt South Atlantic has a disproportionate share of the proprietary and private non-profit agencies. The Middle Atlantic region appears to be heavily influenced by hospital-based agencies.

Like most service-producing organizations, home health agencies are more likely to be found in urban areas, which have sufficient concentration of patients to make their activities worthwhile. In many cases, it is left to government agencies to fill needs in rural areas where service provision must be subsidized. According to industry sources, home health care is not available at all in some rural areas.

Agency size differs systematically by type. As shown in Exhibit 1-9, VNAs, historically the oldest and largest type of home health agency, tend to be largest in terms of Medicare visits per year. Average Medicare reimbursement by agency type corresponds closely to the number of visits. Thus, VNAs, on the average, also receive the largest reimbursements from Medicare, although their reimbursement per visit is somewhat below that of

EXHIBIT I-8

DISTRIBUTION OF MEDICARE CERTIFIED HOME HEALTH AGENCIES BY
GEOGRAPHIC DIVISION WITHIN AGENCY TYPE
1974 AND 1980

	All Agencies		Visiting Nurse Associations		Combined Gov't Voluntary		Government		Hospital Based		Proprietary, PNP, Other	
	1974	1980	1974	1980	1974	1980	1974	1980	1974	1980	1974	1980
United States	2,329 (100.0%)	2,829 (100.0%)	532 (100.0%)	510 (100.0%)	52 (100.0%)	50 (100.0%)	1,298 (100.0%)	1,272 (100.0%)	269 (100.0%)	344 (100.0%)	178 (100.0%)	653 (100.0%)
New England	14.7	11.2	44.7	41.6	17.3	6.0	5.2	4.2	9.3	6.1	1.7	4.1
Middle Atlantic	12.1	9.9	17.5	18.0	9.6	10.0	6.9	5.8	31.9	23.2	4.5	4.6
East North Central	14.4	15.3	16.2	16.7	21.2	22.0	14.6	16.1	12.3	13.9	8.9	12.9
West North Central	10.5	12.2	4.7	3.9	9.6	22.0	13.4	18.9	13.8	13.7	1.9	4.1
South Atlantic	14.5	14.3	5.1	7.8	23.1	14.0	19.3	12.3	7.4	8.7	16.3	26.0
East South Central	12.8	14.5	1.7	1.8	0.0	10.0	19.6	20.8	8.2	10.5	7.3	14.7
West South Central	10.9	10.8	2.1	2.2	1.9	6.0	13.7	13.4	2.6	4.1	32.0	16.2
Mountain	3.9	4.5	2.2	1.9	9.6	10.0	3.9	5.3	4.8	6.7	5.6	3.4
Pacific	6.2	7.3	5.8	6.1	7.7	0.0	3.4	3.1	9.7	13.1	21.9	13.9

Source: Health Care Financing Administration, unpublished statistics.

EXHIBIT 1-9

AGENCY SIZE BY TYPE OF AGENCY, 1982

Type of Agency	Average Visits/ Year	Average Medicare Reimbursement/Year
VNA	21,453	$723,957
Combined Government Voluntary	6,700	253,559
Government	3,663	119,545
Hospital-Based	6,758	303,759
Proprietary	5,329	205,328
Private Non-Profit	12,021	423,401
ALL AGENCIES	8,357	$299,868

Source: HCFA, Unpublished data.

most other agency types. Government and government-related agencies are the smallest agencies in terms of visits and reimbursements. This may partly reflect the usually limited range of services offered by these agencies.

Differences also exist in the scope of services offered by the home health agencies. As seen in Exhibit 1-10, while all of the agencies provide skilled nursing services (as required by Medicare) and most also provide home health aides, other services, particularly the therapies, are less routinely available. In addition, it appears that while many of these services are offered by the agencies, they are not provided directly, but through arrangement with other individuals or groups.

There are little data available that might be used to assess whether severity of illness differences exist by type of agency. One proxy measure may be number of visits. Referring to Exhibit 1-11, proprietary and private non-profit agencies appear to provide patients with more visits per person than the average for all agencies, but differences among the average number of visits per patient by agency type have been decreasing over time. Information is not available on referral sources or discharge destinations by agency type.

Finally, differences appear in the average per visit charge to Medicare by agency type (Exhibit 1-12). The growing agency types, i.e., hospital-based, private non-profit, and

EXHIBIT 1-10

Proportion of Home Health Agencies Providing Various Types of In-Home Services
January 1984

Type of Service Offered	Total	By Agency Staff	By Contractual Arrangement
Skilled Nursing	100.0%	98.6%	1.4%
Physical Therapy	83.0	52.0	31.0
Occupational Therapy	49.3	28.9	20.4
Speech Therapy	65.4	35.7	29.7
Medical Social Services	52.8	40.4	12.4
Home Health Aide	94.5	84.4	10.1
Interns and Residents	0.8	0.5	0.3
Nutritional Guidance	23.8	17.8	6.0
Pharmaceutical Service	6.4	3.5	2.9
Appliances and Equipment	23.0	11.6	11.4

Source: Health Care Financing Administration, Providers of Service File, unpublished

EXHIBIT 1-11

Visits per Person Served by Type of Agency
1974 - 1980

YEAR	ALL AGENCIES	VNA	COMBINED GOV'T AND VOLUNTARY	GOV'T	HOSPITAL BASED	PROPRIETARY	PRIVATE NON-PROFIT	OTHER
1974	10.6	18.9	18.9	20.5	19.3	31.2	32.8	23.8
1980	23.4	22.4	22.4	20.6	21.2	25.7	28.8	23.6
1982	26.27	25.5	20.6	22.3	22.6	30.5	31.8	26.0

Source: 1974 Data: USDHEW, ORS Health Insurance Statistics, Medicare Utilization of Home Health Services 1974"

1980 and 1982 Data: HCFA, unpublished data

EXHIBIT 1-12

Average Medicare Charge Per Visit - 1974, 1980, 1982

YEAR	ALL AGENCIES	VNA	COMBINED GOV'T AND VOLUNTARY	GOV'T	HOSPITAL BASED	PROPRIETARY	PRIVATE NON-PROFIT	OTHER
1974	$17	$16	$18	$15	$21	$20	$24	$19
1980	33	29	32	26	38	38	39	32
1982	40	36	40	32	50	46	43	40

Source: HCFA, unpublished data

proprietary, have higher per visit Medicare charges than the traditional types, VNA and government. Differences in average charges may reflect range of services offered by the different types of agencies in addition to different organizational structures.

Subcontractors.

Subcontracting provides a means for home health providers to supply services to Medicare beneficiaries without certification or direct reimbursement by Medicare. Most subcontractors are individual therapists, nurses, and aides, but some are other corporations. Exhibit 1-10, presented earlier, shows that subcontracting arrangements are most common for physical, speech, and occupational therapy, where 35 to 45 percent of the agencies supplying these services do so through arrangements with others rather than using their own staff. This implies that contracting mechanisms are already widely employed in home health.

Payors.

Medicare. The growing size of the Medicare home health market is shown by the expenditure trends in Exhibit 1-13. The exhibit shows that Medicare reimbursement since 1974 has increased dramatically. The annual compounded rate of growth during this time period has averaged more than 30 percent per year. Between 1980 and 1982, this rate of growth has only slowed

EXHIBIT 1-13

MEDICARE REIMBURSMENT FOR HOME HEALTH BY PROGRAM
AND BY TYPE OF ENROLLEE, 1974-1982
($ IN MILLIONS)

	1974	1975	1976	1977	1978	1979	1980	1981	1982	Annual Rate of Growth 1974-82	Annual Rate of Growth 1980-82
Total Reimbursement	$132.7	$207.5	$284.5	$360.4	$431.8	$520.1	$654.4	$813.9	$1091.3	30.2	29.1
Part A	94.4 (71.1%)	145.6 (70.2%)	200.1 (70.3%)	255.1 (70.8%)	311.0 (72.0%)	377.7 (72.6%)	473.8 (72.4%)	665.7 (81.8%)	1068.0 (97.9%)		
Part B	38.3	61.9	84.4	105.3	120.8	142.4	180.6	148.2	23.3		
Total Reimbursement Aged							601.0 (91.8%)	748.5 (92.0%)	1003.4 (91.9%)		29.2
Total Reimbursement Disabled							53.3	65.4	87.9		28.4
% of Total Medicare Reimbursement	1.1%	1.4%	1.6%	1.7%	1.8%	1.9%	2.0%	2.1%	2.3%		

Source: Health Care Financing Review, Summer 1983; 4(4); Fall 1984 6(1)

slightly. This exhibit also reflects changes in reimbursement due to the introduction of OBRA 1980. Prior to 1981, reimbursement for home health services was split 70/30 between Parts A and B. After enactment of OBRA, these percentages shifted drastically, until, today, almost all home health services are provided under Part A. In addition, the exhibit demonstrates that disabled persons have, at least in the last few years, accounted for little of the home health services reimbursement. The Medicare home health market is clearly growing rapidly. Home health services currently account for 2.3 percent of all Medicare reimbursement, a seemingly minor amount, until one considers that eight years earlier, this figure was 1.1 percent.

Preliminary data for 1983, indicate that rapid growth in Medicare expenditures is continuing. According to data supplied by HCFA, Medicare home health care expenditures increased 27 percent in 1983 over the previous year.

Home health services under Medicare are reimbursed on a reasonable cost basis up to prospectively set limits specified under Section 1861 (v)(1) of the Social Security Act. Limits are established by type of service and are expressed as costs per visit. However, limits are applied to each home health agency as a single aggregate limit, based on the agency's sum total of number of visits for each type of service.

A national schedule of limits on home health agency costs per visit is usually published annually with the most recent appearing July 2, 1984 (49 FR 27272). The schedule specifies, for metropolitan and non-metropolitan areas, a base limit for each type of service, first as a total and then broken into the labor and non-labor portions. Adjustments are then made to this limit in the following manner in order to arrive at an agency-specific cost per visit limit:

1. An adjustment is made to the labor-related component by multiplying by the hospital worker wage index for that area. This is then added back into the non-labor portion to arrive at the adjusted per visit limit.

2. An inflation adjustment to the total is made upward that corresponds to the month and year in which the agency's cost reporting period begins.

3. If an agency is hospital-based, an additional add-on amount is made to both the labor and non-labor portions of the base limit.

In order to determine the maximum reimbursement for an agency, each service-specific adjusted limit is multiplied by the number of that type of visit provided. These are then summed together to arrive at the maximum allowable agency limit.

Medicaid. The second largest purchasers of home health services are the state Medicaid programs. Between 1972 and 1983 Medicaid payments for home health grew from $24 million to almost $600 million, an average annual increase of 33.5 percent. This amount, however, now accounts for only 1.8 percent of total Medicaid payments (see Exhibit 1-14). One state, New York, accounted more than three-quarters of all Medicaid-funded home health. The next largest states were Massachusetts - 2.8 percent, New Jersey - 2.6 percent, and Georgia - 1.4 percent. All 46 other states combined contributed 16.4 percent of all Medicaid home health payments.

Medicaid reimbursement practices, along with range of services, vary across states, with more than half (27 states) piggybacking onto Medicare policies. That is, in these states, reasonable costs are allowed so long as they do not exceed Medicare rates. Some states, such as Idaho and Vermont, have policies that payments must not exceed the lower of (a) reasonable costs as determined by Medicare, or (b) maximum payments per visit, set by a state agency. Minnesota allows customary charges which are reasonable, so long as they do not exceed the state's Medicaid SNF rate.

Other Payors. Other payors of home health services include private insurance companies and HMOs/PPOs and self-pay patients. Increasingly, private payors are focusing on home health as a benefit which can reduce inpatient hospital stay and

EXHIBIT 1-14

HOME HEALTH CARE PAYMENTS
UNDER MEDICAID, 1972-1983

Year	Payments (Millions)	Percent of Total Medicaid Payments
1972	24	0.4
1973	25	0.3
1974	31	0.8
1975	70	0.6
1976	134	1.0
1977	180	1.1
1978	210	1.2
1979	263	1.3
1980	332	1.4
1981	428	1.6
1982	496	1.7
1983	597	1.8
Average Annual Rate of Growth, 1972-1983	33.5	15.6

Source: Health Care Financing Review, Fall 84, 6(1)

reduce overall claims cost. According to sources at the Health Insurance Association of America, most group health insurance policies do cover home health care. A 1984 survey of private group benefit plans, conducted by the Wyatt Company, found that 71 percent of group policies provided home health care. This reflected an increase from only 10 percent, two years earlier. The increase in groups providing home health benefits far exceeded the increase for any of the other "cost containment" provisions reported. Many HMO programs currently also provide home health care benefits. However, the use of home health care under both of these health benefit groups has been minimal. These groups primarily cover younger persons not usually associated with the need for home health care, and hence, demand for these services has been negligible. Data are not available on the extent of self-pay for home health care services, but it is thought to be quite small.

Some payments for home care are also made under the Title XX program for services provided to the elderly and low income individuals. These services are, however, of a low skilled and social service nature, and not the skilled type focused on in this report.

Thus, although the total capacity of the home health industry is not limited to that funded by Medicare, and a shift in Medicare reimbursement policy could theoretically shift suppliers to other markets, Medicare is by far the largest

purchaser of home health services. Medicare payment methods will essentially determine prices and supply for this industry.

Total Home Health Expenditures. As indicated earlier, home health expenditures are available for the Medicare and Medicaid programs, but not for private insurance, direct patient payment, charitable sources and other payment sources combined. Medicare payments increased from $208 million in 1975, to 1,091 million in 1982, and to about $1.5 billion in 1983. Medicaid payments rose from $70 million in 1975 to $596 million in 1983. Predicast, Inc., a marketing research firm, estimates that 1983 "primary home health care" expenditures were (exclusive of durable medical equipment) $2.6 billion in 1983 (Hospitals, December 1, 1984, p. 28). Based on these estimates, Medicare and Medicaid combined allowed for slightly over 80 percent of total home health care services. Predicast projects that expenditures for home health care will increase to $5.2 billion in 1988, and to $10.6 billion in 1995. These projections reflect expenditure trends over the past few years as well as the underlying factors responsible for growth in home health care use: primarily, continued rapid growth in the aged population, growing consumer preference for home rather than institutional care, and efforts under both the Medicare and Medicaid programs to reduce inpatient hospital and nursing home usage.

1.3 Overview of Market Study Methodology

A two stage methodology was employed for the home health care market study. First, we evaluated the literature available to provide a national perspective of the home health care services market. Information and data were sought from publications, state and federally-sponsored research, and from direct interviews with selected researchers and national representatives. Information sought related to important economic characteristics of the home health care industry, including levels of and changes in costs, prices, payment levels of different payors, volume, agency numbers and size, market area definition, and qualitative information on the extent and methods of agency competition.

The second stage of the market study was the performance of three limited market studies. The studies focused on Medicare covered skilled services, provided by Medicare-certified agencies. An overview of the methods used in these studies, including site selection, persons interviewed, and data collection procedures is presented in the remainder of this section. Little information is provided on the market for homemaker and other non-Medicare covered service, even though many Medicare-certified agencies provide these services as well.

1.3.1 Site Selection

The three study sites selected, after consultation with

HCFA, were Sacramento and Stockton, California; New Orleans, Louisiana; and Boston, Massachusetts. In selecting the study sites we tried to achieve some representativeness of the country as a whole. We sought to identify markets that not only differed geographically, but by size and utilization. Additional factors that weighed in the selection process were variability in available health resources, predominant agency type in the area, numbers of agencies, utilization of services and project staff knowledge of the health care systems in those areas.

Demographic and health care resource data for each of the market sites are provided in Exhibit 1-15. These data on the supply of hospital beds, nursing home beds and physicians, as well as population, aged population and population density form part of the overall health care environment that may help to explain home health care use patterns and market characteristics at the market study sites. The exhibit will be referred to in subsequent chapters.

1.3.2 Information Sources

At each site we sought interviews with:

- Freestanding/non-hospital Medicare-certified home health agencies, i.e., voluntary, governmental, proprietary and not-for-profit
- Hospital-based Medicare-certified home health agencies
- Hospital discharge coordinators

EXHIBIT 1-15

SELECTED DEMOGRAPHIC AND HEALTH RESOURCE CHARACTERISTICS
OF MARKET STUDY SITES, 1983

Metropolitan Area	Population[1] 1983 (000's)	Percent of Population Aged 65 and over[2]	Area in Square Miles	Persons per Square Mile	Hospital Beds per 1000 persons[3]	Nursing Home Beds per 1000 Persons Age 65 and Over in State[4]	Practicing Physicians Per 1000 Persons[5]
U.S. Total	230,116	11.3	3,534,289	65	4.4	64.8	1.7
Boston NECMA	3,673	12.2	2,429	1,512	3.7	58.9	2.9
New Orleans MSA	1,316	9.3	2,406	547	5.2	64.7	2.3
Sacramento MSA	1,197	9.6	5,117	234	3.0	49.1	1.8
Stockton MSA	378	11.3	1,415	267	2.7	49.1	1.4

1. U.S. Bureau of the Census, unpublished data for 1983
2. U.S. Bureau of the Census, Census of Population, State/Metropolitan Data Book, 1980
3. American Hospital Association, Hospital Statistics, 1984 edition
4. HCFA, unpublished data, SNF and ICF beds certified as of 1/84
5. American Medical Association, Physician Characteristics and Distribution in the U.S., 1983 edition, total non-federal physicians

- State home health associations
- Third-party payors
- Medicare and Medicaid program and intermediary personnel.

In each site we conducted between 15 and 25 interviews. Several of the interview subjects were extremely helpful, supplying copies of state regulations, proposed changes, and copies of agency literature and price sheets. Payors were particularly cooperative, supplying us with data on expenditures for and utilization of home health services for their beneficiaries. They also provided annual agency cost reports, when they were available.

1.3.3 Data Instruments

Six different interview guides were developed for the different interview subjects, namely: freestanding agencies, hospital-based agencies, referral agents, associations, regulatory officials and payors. Copies of these guides can be found in Appendix A. While all interviewees were cooperative, there were some subject areas on which respondents felt ill-prepared to provide information. In some cases persons could not respond completely to questions concerning competitive bidding because of their unfamiliarity with it and its

applicability in home health. However, all groups questioned did, to the best of their abilities, respond fully.

1.4 Outline of Report

The remainder of this report focuses on the limited market studies. Chapter 2 presents findings of the Sacramento and Stockton, California market site visits. The next two chapters address the New Orleans and Boston markets, respectively.

Each market report is organized in a similar manner. The area is first described in terms of economic, demographic, health care and regulatory characteristics. This is followed by a discussion of market definition, the nature of competition among agencies and patterns of care. Finally, sections are presented on market reactions to Medicare and Medicaid regulations and reimbursement, and reactions and alternatives to competitive bidding.

The final chapter of this report presents a summary of our findings and conclusions. In addition, implications of the findings of the market studies on the development of successful competitive bidding models is discussed.

2. SACRAMENTO AND STOCKTON, CALIFORNIA

Prepared by:
Nancy Hurwitz and Zachary Dyckman

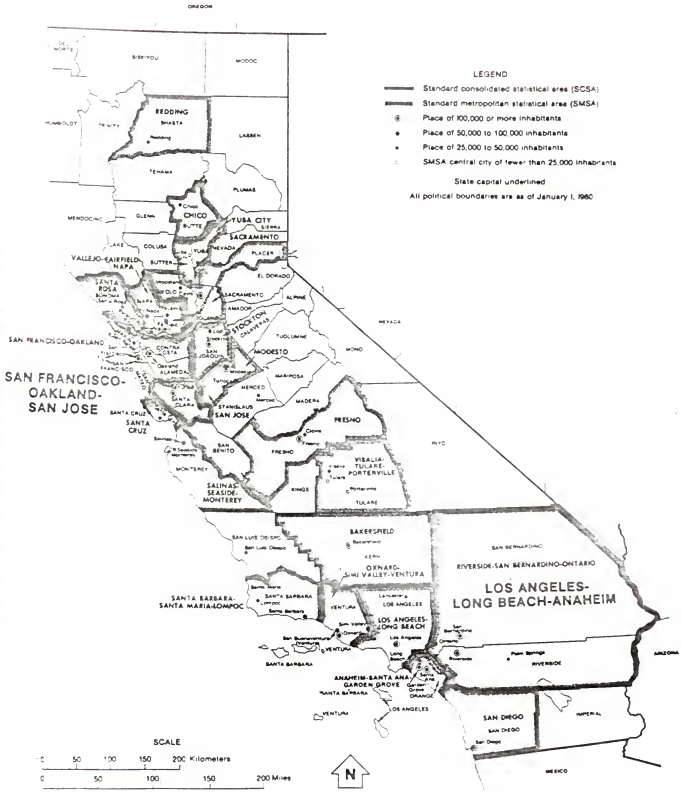
2. SACRAMENTO AND STOCKTON, CALIFORNIA

2.1 Economic, Demographic and Health Care Environment

Sacramento and Stockton are located in the central valley portion of California, wedged between the coastal shore and the Sierra Nevada mountains (see map). Sacramento, the major city in the Sacramento Metropolitan Statistical Area (MSA), is located 85 miles northeast of San Francisco, in the Sacramento Valley formed by the junction of the Sacramento and American Rivers. In 1983, the population of the Sacramento MSA was 1.2 million, as shown in Exhibit 1-15. Almost three-quarters of the population resided in Sacramento County, while the remaining resided within Yolo, El Dorado and Placer Counties. Stockton, which is 50 miles south of Sacramento, had a 1983 population of 378,000. All of these inhabitants lived within San Joaquin County. The population densities of the Sacramento and Stockton MSAs were 234 and 267 persons per square mile, respectively, substantially lower than the other market study sites. The proportion of the population age 65 and older in Sacramento and Stockton was 9.6 percent and 11.3 percent, respectively, compared to 11.3 percent for the United States as a whole.

The Sacramento area is characterized by a diverse economic base formed by a combination of government, manufacturing, and agricultural elements. The city is the state capital of California and is, thus, a center for governmental activities.

MAP: SACRAMENTO/STOCKTON AREA



Manufacturing in the area produces consumer products, computer electronics, and agricultural products. The city is the center of wholesale and retail activity in the Sacramento Valley. In addition, several universities are located in the area, including the University of California Medical School and the University of California at Davis.

The economy in Stockton is primarily based on agriculture. Other significant sectors consist of food processing, light manufacturing, and military installations.

The Sacramento MSA has 16 hospitals with a total of 3,269 beds. This means that there are approximately 3.0 acute care beds per 1,000 persons, which is substantially below the national average of 4.4 beds per 1,000 persons (See Exhibit 1-15). The supply of nursing home beds in California at 49.1 per 1,000 persons 65 and over, is similarly below the national average of 64.8 per 1,000 aged persons. (Nursing home data are not available on a city or metropolitan area basis.)

The total number of non-federal patient care physicians in the Sacramento MSA is 2,118, or 1.8 per 1,000 persons. This is about even with 1.7 physicians for the state and 1.7, nationwide.

The Stockton MSA has eight hospitals with a total of 1,016 beds, or 2.7 beds per 1,000 persons. The total number of non-federal practicing physicians in Stockton is 525, or 1.4 per 1,000 persons.

2.1.1 Regulatory Environment

California has traditionally been both a heavily regulated state and a highly innovative state as regards health. While health planning and Certificate Of Need have been major forces in shaping health care in California, the State has also legally mandated the use of competitive bidding for the purchase of acute care services under its Medicaid (Medi-Cal) program, and encouraged the use of innovative hospital service purchasing arrangements by private payors. These regulations, however, have not been directly (or explicitly) extended to home health.

In order to be a Medicare certified home health agency in California, licensure is required. Discussions with state officials and a review of the regulations indicate that licensure requirements do not, usually, go beyond those of Medicare certification. One exception may be that qualifications for the Director of Nursing and Nursing Supervisor may be more stringent under California law. To provide Medi-Cal home health services, the agency must be licensed by the state and Medicare-certified.

It is possible to provide home health services (i.e., be licensed) without being certified, if the agency sees only private pay patients. However, because the volume of private pay patients is very low and many private insurers are now using Medicare certification as an eligibility criterion for reimbursement, there is little reason for an agency not to seek

certification in addition to state licensure. In fact, no agency, to date, has done this.

State regulations do not appear to favor any one particular type of agency.

Probably because of the strong regulatory environment and state-wide experience with competitive bidding, very little negative reaction to competitive bidding by any of the parties interviewed was encountered. However, many did feel that in order to assure adequate levels of quality, stricter regulation of successful bidders may be needed.

Many agencies have lines of business that basically escape home health regulation and licensure, and are only covered under business licenses. These agencies had private sides that provided for continuous staffing, some with lower skilled personnel. These groups provided nursing services, homemaker and respite services that are not covered under Medicare due to its intermittent and skilled care rules. Most of these agencies felt this separate side of their business was necessary to their survival due to increased competition and tightening of Medicare rules.

2.2 Definition of the Market: Geographical

The home health care market is first defined artificially by Medicare regulations and state licensing regulations. Medicare

recognizes a provider's service area as being a 50 mile radius around the provider. Agencies that choose to open other offices within that 50-mile radius are licensed separately but certified together and are considered branch operations. Using this definition, the Sacramento market includes all of Sacramento and Yolo counties, the western portions of Placer and El Dorado counties and the southern parts of Sutter and Yuba Counties. This area is significantly larger both in terms of area and population than the Sacramento MSA. A second factor also contributes to defining markets. There is a preference of referral agents, such as hospital discharge planners, to use agencies that have a local interest and a familiarity with their community. A third factor, which is related to the others mentioned, is the increased cost of providing services in areas that require substantial travel time and expense. These factors tend to result in home health care markets that are defined as a city and its surrounding suburban communities. We identified four distinct markets in the Sacramento and Stockton area, an area that was originally considered to be a single, fairly homogeneous market. These markets are: the city of Sacramento and its surrounding suburbs, the city of Stockton and its surrounding suburbs, Lodi and a small community northeast of Sacramento.*

*The "small community northeast of Sacramento" is not identified to preserve the confidentiality of interview responses for a specific provider.

2.3 Definition of the Market: Cost and Utilization

The home health market may also be defined in terms of expenditures for home health care and volume of services provided. Unfortunately, no single repository of these data exists.

Total use of and revenues for home health care (as defined by Medicare) are unknown. However, due to the nature of the industry and reports of the individual agencies, approximately 90 percent of all users of home health services are age 65 and older, it is reasonable to assume that Medicare use and expenditures alone are about equal to the totals. Based on unpublished data obtained from HCFA, Medicare home health expenditures during 1983 were $6.7 million and $1.6 million, respectively, for Sacramento and Stockton. For the two areas combined, Medicare costs have more than tripled since 1981.

Originally, data on costs of home health care were to be obtained from Blue Cross of California, the state designated Medicare home health intermediary. It was understood that Medicare expenditures would be understated using this source due to the fact that agencies may choose to use other intermediaries. Each state has a designated intermediary. In addition, an agency has the option of using an alternate instead of the designated intermediary. For California the alternate is Blue Cross of

Iowa. In the instance of proprietary chains, a third choice exists. The local office of the chain may use the designated intermediary appropriate to the chain headquarters. Of the 313 agencies in California, approximately 250 use Blue Cross of California as their intermediary. Many of the large chains, such as Beverly and Upjohn, use other intermediaries.

Medi-Cal, which individual agencies reported accounts for zero to seven percent of their business, had expenditures for home health during FY84 of $4,091,710 for the entire state: $117,519 was spent in Sacramento County and $62,194 in San Joaquin County. For the state as a whole, Medi-Cal program expenditures for home health represented less than 0.1 percent of total expenditures for that period. The relatively low Medi-Cal expenditures for home health may be due to a number of factors. First, Medi-Cal clients are usually younger and are, therefore, low users of home health. Perhaps more important, many agencies take Medi-Cal clients only when they are pressured to do so by referral agents because reimbursement rates are claimed by the agencies to be below levels necessary to cover the cost of providing the services.

Medi-Cal expenditures for home health, cited above, probably do not include expenditures for those services provided under the Medicaid Home and Community-Based Care Waiver program (Section 2176). In California, the 2176 Waiver Program is called the Multi-Specialty Senior Project (MSSP), and is administered

through the counties; thus, it is not provided uniformly across the state. Counties have the option of providing some, all, or none of the services. Further, MSSP services go far beyond those of Medicare-recognized services. MSSP services include:

- Adult social day care
- Housing assistance
  - Repair
  - Maintenance
- In-home supportive services supplementation (IHSS)
  - Chore
  - Health care
  - Protective supervision
- Case management
  - Client assessment
  - Care planning
  - Service delivery
- Respite care
  - In home
  - Out of home
- Transportation
  - Regular
  - Medical
  - Escort
- Meal services
  - Congregate
  - In home
  - Food
- Protective services
  - Social and reassurance services
  - Therapeutic counseling
- Special communications
  - Translation
  - Devices.

These services are provided by both Medicare certified and non-certified agencies. Because of the county control of MSSP funds, estimates of expenditures under this program were not available from state government sources.

On the private side, users of home health care can be classified into three groups: self-pay, private insurance and HMO/PPO business. Agencies interviewed reported that these together accounted for three to eight percent of their business in the Sacramento and Stockton areas. Blue Cross of California indicates little demand for home health benefits among health insurance purchasers. Agencies are reporting that the HMO and PPO business is growing, but currently represents a minimal portion of their market. Many HMOs and PPOs are asking agencies to bid competitively to act as their home health agency. However, several agencies expressed disinterest in dealing with the HMO/PPO competitive process because of the extremely low potential patient volume.

Another measure of the size of the market is the volume of services provided. Because of the method of Medicare reimbursement, service provision is measured in terms of visits. During 1983, 148,940 home health visits were provided under the Medicare program in the areas visited. In Sacramento and Stockton 123,291 and 25,549 visits were provided, respectively. Average number of visits made to each patient by agencies ranged from 16 to 24.

Exhibit 2-1, provides information on the distribution of home health visits between 1981 and 1983. Over the course of these years, the total number of visits increased 129 percent. Although no radical changes in the distribution of services is

EXHIBIT 2-1

NUMBER OF VISITS BY TYPE
OF SERVICE BY YEAR -
MEDICARE
SACRAMENTO/STOCKTON

TYPE OF SERVICE	YEAR					
	1981		1982		1983	
	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total
Skilled Nursing	31,322	48.2	44,117	45.9	67,148	45.1
Physical Therapy	6,843	10.5	11,238	11.1	18,749	12.6
Speech Therapy	1,999	3.1	2,406	2.5	3,444	2.3
Occupational Therapy	1,737	2.7	3,303	3.4	4,270	2.9
Medical Social Services	518	0.8	1,080	1.1	2,441	1.6
Home Health Aide	22,573	34.7	34,017	35.4	52,784	35.5
Other	7	<0.1	10	<0.1	4	<0.1
TOTAL	64,999	100.0	96,171	100.0	148,840	100.0

Source: HCFA, unpublished data

apparent from the table, indications are that physical therapy and medical social services are increasing in relative importance, while skilled nursing is declining. Despite the relative decline, the number of skilled nursing visits more than doubled between 1981 and 1983. The increasing importance of physical therapy is reinforced by several of the agencies interviewed indicating that they are seeking to specialize in rehabilitative care, both for Medicare and non-Medicare covered individuals.

During fiscal year 1984, Medi-Cal provided benefits for 113,838 visits state-wide: 3,161 visits in Sacramento County and 1,632 in San Joaquin County. No further breakdown is available.

Data on home health services provided are not available for private-side users. Based on estimates provided by agencies in the Sacramento and Stockton areas, private visits may represent approximately 5 percent of total visits.

2.4 Market Concentration

As of June 30, 1984, according to HCFA, there were a total of 21 Medicare-certified agencies in the Sacramento and Stockton area: 17 in Sacramento and four in Stockton. In addition, the home health care market may be viewed as being supplemented by those groups that offer other home care services not covered by Medicare: those of a less skilled and/or continuous nature.

In preparing for the market study, however, it was noticed that several of the agencies thought to be "active" had ceased operation. This was further confirmed during the market study, as all of the agencies interviewed indicated that only 14 agencies were currently doing business in Sacramento. All of the originally identified agencies in Stockton were confirmed.

The market immediately around Sacramento is highly concentrated. This is shown in Exhibit 2-2. While there were 9 agencies which provided services to Medicare beneficiaries in 1983, 60 percent of the services were provided by a single agency, a VNA. The top five agencies in Sacramento accounted for 95 percent of home health care visits. The distribution by charges was virtually identical to that of visits. While the voluntary agency had 60 percent of the market, it was reported by area agencies that this is a much smaller share of the market than it had just two years ago. In fact, all agencies interviewed remarked about their shrinking market shares due to the entrance of more agencies into the market, particularly hospital-based agencies. Some evidence of joint ventures between existing hospitals and agencies as a method to increase their volume was seen.

In the smaller cities north and east of Sacramento, the market is slightly different. This area is served largely by branches of Sacramento agencies. One hospital visited in a small town 25 miles from Sacramento that had a large Medicare clientele

EXHIBIT 2-2

MEDICARE MARKET SHARES OF SACRAMENTO
HOME HEALTH AGENCIES

1983

TYPE OF AGENCY	VISITS		CHARGES	
	NUMBER	PERCENT OF TOTAL	DOLLARS	PERCENT OF TOTAL
VNA	74,080	60.1%	$3,977,035	59.7%
Proprietary	20,155	16.3	1,138,242	17.1
Proprietary	10,246	8.3	651,166	9.8
Proprietary	8,139	6.6	338,617	5.1
Proprietary	4,136	3.4	213,226	3.2
TOTAL 5 AGENCIES	116,756	94.7%	6,318,286	94.8%
TOTAL ALL AGENCIES(9)*	123,291	100.0%	$6,663,305	100.0%

*Nine Medicare certified agencies were active in Sacramento in 1983.

Source: HCFA, unpublished data

indicated that they would not use agencies located in Sacramento; they insisted upon a local presence. As of August 1984, four Sacramento agencies were operating branch offices there - up from one, two years ago. This would indicate the potential for separate markets in many towns with local hospitals which are a substantial distance from another home health care service area.

Despite their proximity to one another, Stockton is an entirely separate market area from Sacramento. Lodi, which is approximately midway between Sacramento and Stockton is also a separate market. Two agencies serve Lodi, but one, a hospital-based agency, has dominated and continues to dominate the market.

In Stockton, four Medicare certified agencies provided services to beneficiaries in 1983. The largest agency, a hospital-based agency, accounted for 52 percent of Medicare visits and 59 percent of charges. The top two agencies accounted for 81 percent of visits and 83 percent of charges.

It is interesting to note that in this market study, with the exception of the Lodi market, no one particular type of agency really controls the market. While in the past voluntary agencies served the bulk of the home health needs, it now appears that when sufficient population are present, several different types of agencies serve the community.

2.5 Nature of Competition Among Home Health Agencies

Agencies reported that a critical factor in the market is the competition among agencies for referral sources. Hospital discharge planners were identified as accounting for the overwhelming majority of home health care referrals, with physicians a distant second as a referral source, and relatives and friends third. Since most referrals originate with the discharge planner, getting their attention and developing a good working relationship was noted to be the single most important element in the eventual success of a home health agency. On the other side, discharge planners spoke of being bombarded with both literature and phone calls from agencies trying to get them to use their agencies. Some discharge people said that because of this, they are now refusing to talk with agencies with whom they do not already have established relations.

Each of the discharge planners interviewed was asked on what basis home health agencies were selected for referral: how critical are price, quality, reliability and other factors in selecting an agency. The single most important competitive factor cited was the perceived quality of services provided. All agencies participate in at least some quality control programs, usually those required by Medicare: quarterly utilization review, 60-day recertification review and annual advisory group evaluation. However, based on information received from patients or their families, direct discussions with agency personnel or

through other means, hospital discharge planners indicated that they were able to informally assess which agencies were providing services of adequate quality and which were not.

The second selection criterion was range of services offered. Referral agents prefer to use agencies that offer the full complement of covered services rather than having to select one agency to provide skilled nursing and another to provide physician therapy. Agencies also thought this was important. All of the agencies interviewed provided services in all of the six Medicare service areas. In addition, some agencies had "expanded" their service offerings to include the so-called "high tech" services: Intravenous therapy and Total Parenteral Nutrition. Agencies felt that being able to provide all services was not only necessary to compete, but was necessary to provide for continuity of care - another factor in the competitive force.

As an indication of the impact of range of services as a marketing factor, some negative examples were raised. Most notably, some new agencies, in order to gain a foothold, are marketing themselves directly to patients on the basis of being able to provide, under Medicare, a wide range of services - some of which are not actually covered by Medicare - and for a longer period of time. When the improper "expansion of benefits" is discovered, the agency may be forced to close (or already has closed) and services to the patient are terminated, sometimes without prior notice.

Other issues important in competing in the home health arena include:

- Personal rapport with referral agents, i.e., discharge planners and physicians.
- Continuity of care - in this case not the ability to provide all Medicare services, but to offer services not covered, such as private duty nursing.
- Experience - length of time providing services in that area.
- Availability - provision of services 24-hours a day, seven days a week (this is particularly true for IV therapy). This also includes the ability of the agency to respond to a request for new service in a timely manner, usually within one day.
- Community awareness - both knowledge of the community based on a local presence, and having the community aware of the need for and availability of home health care in their area.

It is important to note that not a single agency indicated that price played any role in the competition for home health business.

2.6. Price Variation Among Home Health Agencies

As noted, price plays no role in competition for Medicare home health business. Based on information provided by the agencies, price plays little role in the private sector side of the business as well.

Exhibit 2-3 presents the weighted averages and the range of charges for visits of agencies in the Sacramento and Stockton area, along with the associated Medicare cost caps and Medi-Cal

EXHIBIT 2-3

RANGE AND WEIGHTED AVERAGE CHARGES TO MEDICARE BY
TYPE OF SERVICE AND TYPE OF AGENCY
SACRAMENTO/STOCKTON, 1983
(IN DOLLARS)

TYPE OF AGENCY	TYPE OF SERVICE							
	Skilled Nursing		Physical Therapy		Home Health Aide		TOTAL	
	Range	Avg.	Range	Avg.	Range	Avg.	Range	Avg.
VNA (2)	56.14-59.73	56.54	53.19-55.12	53.31	33.74-35.54	35.37	48.63-49.90	48.72
Other Voluntary (1)	57.00-57.00	57.00	56.00-56.00	56.00	39.00-39.00	39.00	54.59-54.59	54.59
Government (1)	55.07-55.07	55.07	N/A		40.26-40.26	40.26	53.16-53.16	53.16
Hospital-Based (4)	55.00-76.81	68.23	51.86-76.70	67.85	35.00-54.92	48.69	49.95-69.82	61.71
Proprietary (5)	51.24-70.06	55.87	40.46-81.25	57.67	35.91-48.74	39.45	41.75-60.46	49.86
TOTAL (13)	51.24-76.81	58.39	40.46-81.25	56.26	33.74-54.92	38.53	41.75-69.82	51.06
Medicare Limits	57/69*		55/67*		43/54*			
Medicaid	43		40		21			

*Includes hospital add-on

Source: HCFA, unpublished data

reimbursement rates. These "caps" specify, by agency, the maximum that Medicare will reimburse for a particular type of visit. Separate limits are determined for hospital-based and free standing agencies. As can be seen, average charges tend to be close to the Medicare caps. Per visit charges do not appear to differ much among the various types of agencies, except for hospital-based agencies. Hospital-based agency charges tend to run about 20 percent higher than other agencies. This diversion was also seen in prior years for which data were available. Further, it can be seen that Medi-Cal rates are far below those of either the Medicare caps or the individual agency charges. This could explain why agencies are reluctant to take Medi-Cal patients.

According to the agencies interviewed, charges were set at their actual costs. It was reported that a few of the newer agencies had actual costs that exceeded Medicare caps. Higher costs were attributed to high beginning operational costs.

The actual cost of a visit could be distributed over three major categories: labor, transportation and overhead. Labor costs included not only wages for the time actually spent with a patient, but also travel time, time needed for documentation of the visit, and time spent in following up with the patient's physician, discharge planner and family. The second largest component of cost was overhead. Several agencies noted that despite the service being offered in the home, a lot of office

space was needed so that provider personnel had a place for documentation and follow-up activities, and space was required to maintain patient records and other files. As might be expected, transportation was another significant cost component. Medical supplies and pharmaceuticals, and general and administrative costs were considered minor contributors to the entire cost of a visit.

Several agencies did comment on the adequacy of the Medicare limits for certain types of visits. Generally, it was felt that reimbursement levels for the therapies (i.e., physical, occupational and speech) were too low. Most agencies do not have these personnel directly on staff, but instead have individual contracts with therapists. Because these personnel are in short supply and therapy visits tend to be relatively long, actual costs are sometimes higher than Medicare caps. On the other hand, one agency felt that reimbursement for skilled nursing visits may be too high because visits may be relatively short.

In all of the agencies visited, Medicare represented the bulk of their business, generally 80 to 95 percent. Because of this, pricing policies and administrative policies for all patients conformed with Medicare regulations and payment policies. Private payors were usually charged the same as Medicare. Of those few agencies that did use different pricing policies for Medicare and non-Medicare patients, the difference was that private patients were charged on a per-hour rather than

a per-visit basis. Agencies that did this reported that their charges were comparable for visits of the same length of time.

Only one agency reported higher charges for private pay patients than for Medicare - approximately 10 percent higher. The explanation provided indicated that they had to charge private pay patients a higher rate because collection costs were higher and insurance coverage was often uncertain.

2.7 Home Health Agency Use Patterns

Currently, most patients are referred to home health agencies by hospital discharge planners. A distant second referral source is direct physician referral. Family, friends and others also make some referrals. Many agencies are trying to alter this referral pattern by appealing directly to physicians, but efforts are still too new to discern any significant shifts.

Most referral agents may choose several agencies to deal with and then rotate referrals among them. This is not, however, the case with discharge planners in hospitals with their own home health agencies. In these facilities, referrals are made to the hospital-based agency unless otherwise indicated by the physician or requested by the patient. This obviously has implications for the future of independent home health agencies as more hospitals, seeking to expand their service and revenue bases, open their own home health agencies.

Another factor affecting the use and referral patterns of home health is the introduction of DRGs. All agencies reported having a greater number of referrals since DRGs were adopted. Because hospitals are concerned about length of stay, patients are being discharged earlier and many are requiring home health. Several agencies noted that not only are they seeing more patients, but the patients being seen are sicker and require more services, i.e., service intensity is greater.

With the exception of the voluntary and governmental agencies, actual service use is uniform across agency types. Skilled nursing and home health aide visits are most frequently provided, accounting for approximately 80 percent of all visits (See Exhibit 2-4). Therapies, together, accounted for around 19 percent of all visits, with physical therapy most common. Medical social services visits, perhaps because of reported uncertainty of reimbursement, accounted for only about one percent. These percentages may indicate actual need for specific services. On the other hand,the observed usage pattern may in part reflect Medicare coverage and payment policies.

2.8 Reactions to Medicare and Medicaid

In Sacramento and Stockton, there were considerable and consistent home health care agency complaints about Medicare reimbursement and regulation. Problems voiced about Medi-Cal are

EXHIBIT 2-4

DISTRIBUTION OF VISITS IN SACRAMENTO/STOCKTON
BY TYPE OF SERVICE AND TYPE OF AGENCY
1983

	AGENCY TYPE				
TYPE OF SERVICE	VNA	Voluntary	Government	Hospital-Based	Proprietary
Skilled Nursing	43.2%	29.0%	90.4%	52.0%	44.7%
Physical Therapy	14.5	36.2	N/A	11.1	9.8
Speech Therapy	3.0	18.1	N/A	2.0	1.2
Occupational Therapy	3.3	5.9	N/A	1.5	2.8
Medical Social Services	1.3	0.9	N/A	1.7	2.1
Home Health Aide	34.6	10.0	9.6	31.8	39.3
Other	0.1	0.0	N/A	0.0	0.0
TOTAL	100.0	100.0	100.0	100.0	100.0
Total number of visits	81,478	221	478	22,715	43,948
Total number of agencies	2	1	1	4	5

Source: HCFA, unpublished data

best expressed in the phase, "Too little, too late." Agencies consistently commented that while the same services as covered under Medicare are covered under Medi-Cal, payment for those services was too low and it took too long to be paid.

Problems with Medicare can be viewed as falling into one of three broad categories:

- General and administrative
- Intermediary
- Fiscal.

By and large, agencies felt that Medicare regulations are too restrictive and inflexible. They feel caught between the hospital's need to discharge early and their limitation of providing only intermittent care. Further, they feel that rules that allow them to only provide care to improve the status of the patient are counter-productive. All too often, several agencies claim, they are bringing patients up to a good functional level and then are not able to provide the care to maintain them at that level. Instead, the patient regresses until he/she is readmitted to a hospital and/or admitted again to home health to bring the patient back up to the earlier functional status. Because of this cycle, they believe that Medicare should provide coverage for maintenance care under its home health benefit program.

Criticism was also directed towards the program administrative requirements. Agencies cited too much paperwork and documentation as a cause for significant care costs. One agency described the current Medicare administrative system as "[one] designed for the fiscal end and not for good and efficient patient care."

Many of the problems attributed to the intermediary are related to the lack of a clear and uniform definition of what constitutes intermittent care. Agencies claimed that they were never sure of what length of time and what intensity of services were allowed under the "intermittent rule". This was exacerbated in California due to the recent consolidation of the intermediary. Prior to January 1, 1984, two Blue Cross Plans operated as Medicare fiscal intermediaries in the state. Since that time, all home health functions have been consolidated and assigned to what used to be Blue Cross of Southern California. So along with the on-going ambiguity regarding the definition of intermittent care, agencies in the Sacramento and Stockton area stated that they are having to learn how a new intermediary interprets all of the regulations.

In addition to definitional problems, some agencies complained about the new Medical Review system instituted by the home health intermediary in California. In the past, the responsibility for review rested with the intermediary: all providers were required to submit a 20 percent random sample of

open cases. Under the new system, some agencies will submit 100 percent of medical records and treatment plans for review, while some agencies will have no on-going review by the intermediary, but will still have to do internal medical review. Agencies with no prepayment review have had the onus for medical review shifted to them and several complained about this new responsibility. Some agencies with 100 percent review charged that documentation and copying needed for review were unrealistic and costly, particularly for new agencies (all new agencies are in the 100 percent review group). Consensus among the agencies was to return to the earlier Medical Review program.

Concerning reimbursement, the following comments were made:

- Length of time to payment is too long;
- Fiscal auditors sent by the intermediary are not familiar with home health;
- Allocation of costs are unfair to the agencies, particularly those that have other separate but attached businesses.

In addition, and as cited earlier, many agencies felt that payment for services often did not reflect actual costs of

providing the service. In particular, agencies felt that reimbursement for the therapies was underestimated.

Problems with retrospective denials were also raised. Several agencies cited examples of new rulings/interpretations being made by the intermediary and being applied retroactively. This means that agencies provided services on the knowledge and assumption that they were allowable services at the time provided, only to have them denied later because of retroactive application of new rules. Some agencies suggested that a preauthorization system be used to avoid this type of problem.

All of the criticisms made by agencies concerning Medicare and Medicaid payment system policies should be considered in light of providers almost always reacting negatively to payment restrictions. Yet current fiscal realities and the potential for excess utilization when services are provided at no cost to the beneficiaries requires that some restrictions be imposed. Clearly, some would be required under any payment system envisioned.

2.9 Reactions to Competitive Bidding

The concept of competitive bidding was neither shocking nor novel to persons interviewed for the Sacramento and Stockton market study. As already noted, health care in California is both more regulated and more competitive than in most states, and

the idea of the government using competitive bidding to purchase acute care services under Medi-Cal is not unknown. In addition, all of the home health agencies interviewed have been directly exposed to competitive bidding because the HMOs/PPOs (of which there are many in the state) have approached the agencies to bid competitively to serve as the home health care provider for their group.

Despite agency familiarity with competitive bidding and the feeling that it did have the potential to reduce costs in the short-run, agencies did have some concerns about competitive bidding. They did believe that this payment method could be used to purchase home health services, but that the side effects may be less than desirable. The single winning bidder model was generally considered unacceptable. One reason cited was that there would no longer be competition of any kind if only one agency provided services. Multiple winners was more acceptable except that it was felt that it would result in reduced scope of services being offered and less time being spent with the patient. It was also believed that some agencies would provide unrealistically low bids just to get the contract. Finally, agencies felt that the larger and/or chain agencies would have the most success in competitive bidding. Because home health is primarily a service for the elderly covered under Medicare, all other agencies would be driven out of business.

Perhaps the greatest concern raised was that of quality. If the system is based purely on price, how would you maintain or ensure quality services? What incentives would there be for a selected agency to take a complicated case? Every person interviewed felt selection based purely on price would not only be bad for the non-winning agencies, but would be disastrous for the patient. Other factors they felt were important to consider include:

- Scope of service
- Credentials of staff
- Hours of coverage
- Geographic area covered.

No specific recommendations were made on how to ensure quality.

2.10 Other Payment Mechanisms

Agencies generally agreed that the current payment system of cost reimbursement was not really good for either the agencies or HCFA. They realize that cost reimbursement provides minimal incentives for efficiency and cost-effective provisions of services. In fact, keeping "costs" at or near the Medicare limits, by increasing expenses or changing cost allocations is an important objective of many agencies. In addition, agencies did not like cost reimbursement because of the risk of retrospective denials. Agencies describe the move away from cost reimbursement

as inevitable and necessary. Suggestions made as to alternatives to cost reimbursement did not include competitive bidding, but did include:

- Fee schedule - where any agency able to meet the schedule would be recognized;
- Prospective payment system based on capitation;
- DRG-based system;
- System based on an aggregate per visit cost.

2.11 Sources of Information

A variety of sources of information were used in developing a description of the Sacramento and Stockton market. These included aggregate data an costs and utilization from payors and individual cost reports of the agencies visited. In addition, a variety of people were interviewed about home health care in Sacramento and Stockton, California. These included:

- Staff member, Blue Cross of California
- Staff member, Medi-Cal program
- Staff member, Medicare intermediary (Blue Cross of California)
- Executive Director, state home health agency association
- Executive directors of two voluntary home health agencies
- Directors and/or administrators of four proprietary home health agencies
- Directors of three hospital-based agencies
- Discharge planners at four hospitals
- Chief, Licensing and Certification, California Department of Health Services.

3. NEW ORLEANS, LOUISIANA

Prepared by:
Nancy Hurwitz

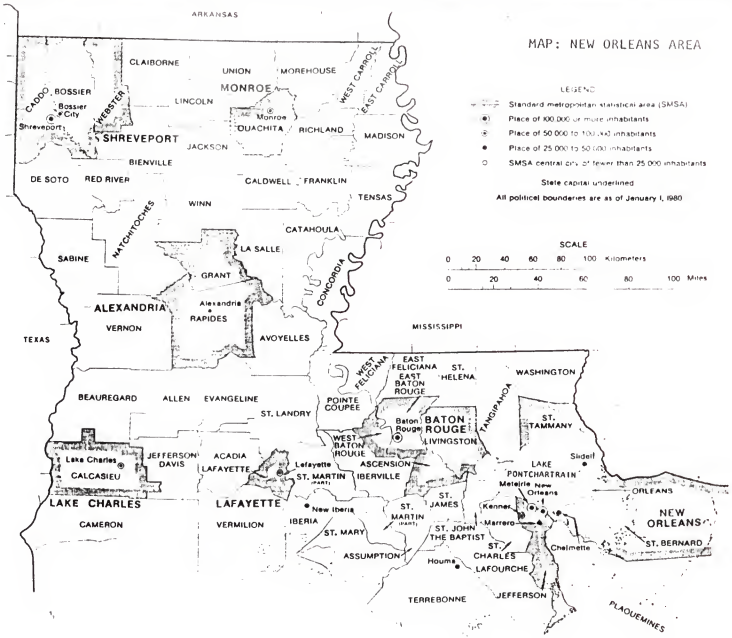
3. NEW ORLEANS, LOUISIANA

3.1 Economic, Demographic and Health Care Environment

The New Orleans metropolitan area is geographically unique. Occupying 2,406 square miles, its northern edge is separated 26 miles from the city by Lake Pontchartrain, and its southern parts are set apart by the Mississippi River and several other major waterways (see map). It includes the parishes of Jefferson, St. Bernard, St. Tammany, St. Charles, St. John the Baptist and Orleans. New Orleans, located in Orleans Parish, is the second largest port in the nation and a major national and international trade center.

Approximately 1.3 million persons live in and around New Orleans, making it the largest city in the state. Of this population, 9.3 percent are aged 65 and older, less than the national rate of 11.3 percent (see Exhibit 1-15).

In spite of its being one of the busiest ports and shipping areas in the world, the general economy of the area is poor. In 1983, the unemployment rate was 10.4 percent, compared to 9.6 percent for the nation. The state of the economy is further reflected in the percentage of persons living in poverty. During the most currently available year, 26.4 percent of the population in the New Orleans area were living below the poverty level -- more than twice that of the country as a whole.


MAP: NEW ORLEANS AREA
LEGEND
Standard metropolitan statistical area (SMSA)
Place of 100,000 or more inhabitants
Place of 50,000 to 100,000 inhabitants
Place of 25,000 to 50,000 inhabitants
SMSA central city of fewer than 25,000 inhabitants
State capital underlined
All political boundaries are as of January 1, 1980
SCALE
0 20 40 60 80 100 Kilometers
0 20 40 60 80 100 Miles
ARKANSAS
CLAIBORNE
UNION
MOREHOUSE
WEST CARROLL
EAST CARROLL
CADDO
BOSSIER
Bossier City
Shreveport
WEBSTER
LINCOLN
MONROE
Monroe
OUACHITA
RICHLAND
MADISON
SHREVEPORT
JACKSON
BIENVILLE
DE SOTO
RED RIVER
CALDWELL
FRANKLIN
TENSAS
WINN
CATAHOULA
SABINE
NATCHITOCHES
LA SALLE
GRANT
CONCORDIA
ALEXANDRIA
Alexandria
RAPIDES
VERNON
AVOYELLES
TEXAS
MISSISSIPPI
WEST FELICIANA
EAST FELICIANA
ST. HELENA
WASHINGTON
EAST BATON ROUGE
BEAUREGARD
ALLEN
EVANGELINE
POINTE COUPEE
ST. LANDRY
TANGIPAHOA
ST. TAMMANY
Baton Rouge
BATON ROUGE
WEST BATON ROUGE
LIVINGSTON
Lake Charles
JEFFERSON DAVIS
ACADIA
LAFAYETTE
Lafayette
ST. MARTIN (part)
IBERVILLE
ASCENSION
Slidell
LAKE PONTCHARTRAIN
Metairie
New Orleans
ORLEANS
CALCASIEU
LAKE CHARLES
LAFAYETTE
New Iberia
ST. JAMES
ST. MARTIN (part)
Kenner
Marrero
NEW ORLEANS
CAMERON
VERMILION
IBERIA
ST. MARY
ST. JOHN THE BAPTIST
Chalmette
ST. BERNARD
ASSUMPTION
Houma
ST. CHARLES
LAFOURCHE
TERREBONNE
JEFFERSON
PLAQUEMINES

The New Orleans health care sector includes two major medical schools - Tulane and Louisiana State University. In addition, the area has 27 community hospitals, including a large, state-operated hospital for the medically indigent.

There are 5.2 hospital beds per 1,000 population in New Orleans, compared to 4.4 beds for the United States as a whole. Further, most hospitals are operating with low occupancy rates of between 45 and 60 percent. The supply of nursing home beds per 1,000 population 65 and over in Louisiana of 64.7 is virtually the same as for the United States as a whole. With 3,088 patient care physicians in the area, there are 2.3 physicians per 1,000 population (see Table 1-15).

3.1.1 Regulatory Environment

Historically, Louisiana health care has not been heavily regulated. There is no Certificate of Need program and health planning in the state has been basically ineffective. An example of this is the severe over-bedding both within the state and New Orleans, specifically. Because of these excessive supply conditions, the Governor recently declared a moratorium on the state licensing of any new health facilities.

State regulation of home health agencies does not go beyond that required for Medicare certification. In fact, current

minimum standards for home care agencies are very vague. Required qualifications and experience of home health care personnel who directly provide the services are minimal, relative to other states. No qualifications are specified for the administrator or supervisory personnel.

Because of the above shortcomings and other vagueries of home health care regulation, the State, with the aid of the Louisiana Home Health Association, is now revising the licensure requirements and minimum standards. A review of the proposed regulatory changes indicates greater specificity, but still not the stringency of California regulations.

The process for licensure in Louisiana is as described below. An agency makes written application for licensure. Currently, because so many groups want to enter the home care business, a provisional license to operate a home health agency is granted for a period of not more than 90 days, after a desk review of the written application. Approximately six to eight weeks following this licensure, an on-site survey of the agency is conducted for final licensure, and if appropriate, Medicare certification.

Licensure regulations and minimum standards do not appear to favor any one type of agency.

Medicare certification in Louisiana does require state licensure. Medicaid requires that the agency be both licensed and Medicare certified before it can be certified by Medicaid to provide services to Medicaid recipients; unlike Medicare, however, Medicaid staff do their own certification inspections.

As in California, certification is not necessary for licensure. Licensed-only agencies may only serve private pay patients. In contrast to California, several agencies in the state do operate on a licensure-only basis. Two of the agencies are in New Orleans.

3.2 Definition of the Market: Geographical

Natural boundaries formed by Lake Pontchartrain and the Mississippi River have helped define the several home health care markets in the New Orleans metropolitan area. Three main markets have been identified:

- New Orleans proper
- "Westbank" of the Mississippi River
- Northside of Lake Pontchartrain.

In addition, some of these large market areas are further broken down into more local areas. This was particularly true across the Lake. Persons interviewed there stressed that a local presence

was absolutely necessary because clients often lived in unmarked areas requiring intimate knowledge of the area. Thus, on the north side of the Lake, at least two markets exist: Covington and Slidell.

The New Orleans proper area is geographically quite large. However, it appears that it represents a single market area. Even Chalmette and Kenner, some 30 minutes from downtown New Orleans were considered the same market. One issue peculiar to this market is service to the "Projects". Many of the city's poor and elderly live in these areas and are being inadequately served due to agencies' unwillingness to see patients there. The basic reason cited is that of safety of personnel.

Agencies on the Westbank appear to serve a larger geographic area than do other agencies in the metropolitan area. They are often called upon to see patients who live in areas as far as 30 to 40 miles away. In addition, this market was also served by two New Orleans based agencies until recently. With the opening of a hospital-based agency on the Westbank, only one New Orleans based agency continues to serve that market.

3.3 Definition of the Market: Cost and Utilization

Aside from geographical limits, the market in the New Orleans area may also be defined by home health care expenditures

and volume of home health services. In Louisiana, there are four distinct groups of home health service consumers:

- Medicare
- Medicaid
- Medically indigent
- Private pay, including self-pay and private insurance.

Data on these groups of users are not collected in the aggregate by any single source. Therefore, to obtain some indication of the extent of the market, groups must be examined individually and pieced together to form a picture of the whole. Examination of the use and revenues expended by each of the above groups is presented in the following paragraphs.

Medicare patients represent the largest income source to Louisiana home health agencies. Except for state and local governmental agencies, care provided to Medicare patients accounted for approximately 95 percent of all agency revenues, at those agencies interviewed. During 1983, 7.6 million Medicare dollars were spent for home health in the New Orleans metropolitan area alone; a growth of 146 percent in just 3 years. Additional Medicare expenditures data are presented below in the discussion of market concentration.

As shown in Exhibit 3-1, the number of visits provided to Medicare clients has also greatly increased since 1981.

EXHIBIT 3-1

NUMBER OF VISITS BY
TYPE OF SERVICE BY YEAR - MEDICARE
NEW ORLEANS

TYPE OF SERVICE	YEAR					
	1981		1982		1983	
	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total
Skilled Nursing	22,414	28.9%	38,771	30.6%	48,751	30.0%
Physical Therapy	14,949	19.2	24,433	19.3	32,096	19.8
Speech Therapy	1,470	1.9	2,621	2.1	3,105	1.9
Occupational Therapy	131	0.2	627	0.5	1,685	1.0
Medical Social Services	132	0.2	496	0.4	773	0.5
Home Health Aide	38,426	49.5	59,866	47.2	75,769	46.7
Other	146	0.2	28	0.1	157	0.1
TOTAL	77,668	100.0%	126,842	100.0%	162,336	100.0%

Source: HCFA, unpublished data

Some small shifts in the distribution of services provided may also be observed in Exhibit 3-1. While home health aide services continues to be the most frequently used service, its proportion of total visits declined from 49.5 percent to 46.7 percent over the two year period. At the same time, physical therapy, occupational therapy, skilled nursing and medical social service visits each increased in relative importance.

The second largest group of patients receiving home health services is that of Medicaid recipients. Medicaid coverage for home health services differs from that of Medicare. In Louisiana, only skilled nursing, physical therapy and home health aide services are included in the Medicaid home health benefit. Further, Louisiana does not participate in the Medicaid "2176" Waiver Program (Home and Community Services). However, unlike Medicare, which requires that patients receive a skilled service in order to be eligible for aide services, Medicaid patients may receive aide services alone. Thus, patients who qualify for both Medicare and Medicaid (cross-overs) and need only aide services, would use Medicaid home health benefits. One final difference from Medicare is that Medicaid home health visits are limited to 50 per year.

Louisiana Medicaid reimburses for home health services at the same rate as Medicare. In fact, cost review for Medicaid is piggy-backed onto the Medicare cost review and is done by the same intermediary.

During FY83, total Medicaid expenditures for home health in the state were $1,195,428. Payments were distributed as follows:

Skilled Nursing	$518,080
Physical Therapy	85,134
Home Health Aide	481,762
Supplies	110,452

This total represents less than 0.2 percent of the total Medicaid program expenditures in the state for that year. With the exception of two governmental agencies which serve large Medicaid populations, agencies interviewed in the New Orleans area reported that Medicaid represented between two and five percent of their revenues.

The Medicaid costs cited above translate into more than 40,000 units of service provided. More specifically, the following volumes of services were rendered to Medicaid clients:

Skilled Nursing	16,526 visits
Physical Therapy	2,612
Home Health Aide	15,993

Further, 8,208 "units" of medical supplies were provided.

Medicaid data specific to the entire New Orleans MSA were not available. However, cost data for Orleans Parish alone were

available for FY83 (note that there are six parishes in the MSA with the majority of the population residing in Orleans Parish). Medicaid home health expenditures during the year were $630,000: approximately half of the total state expenditures for home health. A further breakdown of costs and associated visits were not available. To put the Medicaid home health expenditures in perspective, total Medicaid expenditures for Louisiana represented only eight percent of Medicare home health charges in the New Orleans area.

Another significant user group in New Orleans (and Louisiana) is the medically indigent. Medicaid eligibility rules in this state are extremely stringent and, thus, many that might be covered by Medicaid in other states are not eligible here. All agencies interviewed reported that they do see medically indigent patients, even though in most cases, no reimbursement is received for services provided to these patients. Data provided by the interviewed agencies and discussions with local and state officials indicate that the majority of the medically indigent are seen by state and local government sponsored home health agencies. Data on numbers of visits made or expenditures for services rendered to this group are not available.

Agencies interviewed stated that very little home health service was provided to self-paying patients. Most of the private pay business is from those covered under private insurance, who, according to agency estimates, represent only between two and five

percent of their business. Officials of Blue Cross of Louisiana, which insures more than 40 percent of those insured in Louisiana, stated they have experienced little demand for home health services. While the benefit is included in their standard group package, they estimate that last year only $5,000 were expended for home health services to about 15 beneficiaries.

3.4 Market Concentration

Data received from HCFA indicate that there were 26 Medicare certified agencies in the New Orleans MSA as of June 30, 1984. At the time of the market study, less than three months later, this number had increased tremendously. Based upon talks with state officials and with the Medicare intermediary, there are more than 40 licensed agencies currently operating in the New Orleans area. While no hard evidence of this increase in number of agencies was presented, related indications were offered. According to the State, in less than two months (July to mid-August) the number of agencies in the state grew from 111 to 135, with a large proportion of the new agencies being in the New Orleans area.

Older agencies are spawning new agencies. As described by several observers, often a nurse or other skilled person breaks off from the original agency and forms his or her own agency. The new agency may contract for all other services on an as-needed

basis, until established. Then the process starts all over again. Substantial entry barriers do not exist, as both regulatory and capital requirements to form a new agency are minimal.

As of June 30, 1984, there were 12 home health agencies within the city of New Orleans, nine in Metairie, a major suburb of New Orleans, and one in Chalmette, an eastern suburb. In addition, three agencies operated across the Lake, and at least one on the Westbank.

Agencies in New Orleans, Metairie and Chalmette all serve the same area, i.e., that bordered by the Mississippi River and Lake Pontchartrain, and extending from St. Bernard to St. John the Baptist Parish. Most agencies in this market are local proprietary ones, although chains are beginning to have a presence here. In addition, while as of the end of June 1984, only one hospital-based agency was identified in the area, interviews with other hospitals there indicate that several are considering opening their own agencies. Other expansion in the market has been from local proprietary agencies. Agencies surveyed and others interviewed who were knowledgeable about the area reported that no single agency dominated the market. However, three agencies were continually mentioned as "primary competitors". All were relatively old, well-established, local proprietary agencies. No estimates were provided by the agencies on the proportion of the home health market that they controlled or that other agencies had. In fact, it appeared that agencies had little sense of the

size of the market or market shares. The impression given was that there was enough business for everyone.

Market share data for home health agencies in the New Orleans metropolitan area are provided in Exhibit 3-2. A total of 162,336 visits ($7.6 million in charges) were provided to Medicare beneficiaries by 14 agencies in 1983. The largest agency provided 23 percent of Medicare visits and had 21 percent of charges. The five largest agencies combined, provided 78 percent of the visits and had 68 percent of total charges. Two years earlier, the largest two agencies in New Orleans (the second and third largest in 1983) each provided over 35 percent of total Medicare visits in the New Orleans area. Since then their market shares have diminished, primarily as a result of competition from the newer agencies. Several agencies indicated that they expect market shares of the larger proprietories to decline further as more hospital-based agencies open, and refer their dischanged patients to their own agencies. One agency reported that it recently experienced a 25 percent decline in volume due to the opening of a hospital-based agency.

Of interest is that although there is a VNA in New Orleans, it is not considered an active competitor by other agencies. The VNA has chosen to become neither Medicare nor Medicaid certified, and, thus, sees only self-pay and no-pay patients (i.e., medically indigent). In addition, it was reported that they do serve an

EXHIBIT 3-2

MEDICARE MARKET SHARES OF NEW ORLEANS
HOME HEALTH AGENCIES
1983

TYPE OF AGENCY	Visits		Charges	
	Number	Percent of Total	Dollars	Percent of Total
Proprietary	37,034	22.8%	$1,619,558	21.4%
Proprietary	28,194	17.4	895,850	11.9
Proprietary	24,572	15.1	1,092,282	14.5
Proprietary*	19,652	12.1	822,527	10.9
Hospital-Based	16,306	10.0	741,313	9.8
Total 5 Agencies	125,758	77.5	$5,171,530	68.5
TOTAL ALL AGENCIES (14)	162,336	100.0%	$7,554,436	100.0%

*Not in New Orleans Proper

Source: HCFA, unpublished data

area that most other agencies prefer not going into: the "Projects".

Another major market area is that across the Lake from New Orleans. Two smaller market areas in this area are identified by the cities of Covington and Slidell. The market study observed primarily only one of these cities. Two agencies served the area, one of which had split off from the other over a year ago. While no market share data were available, the original agency in the area reported no decrease in market activity in the year since the new agency opened. Both are local proprietary agencies, and provide the full range of Medicare services. Additional groups in the area do provide continuous care services and are not considered a part of the market. Neither of the two hospitals in the area have or are planning to open home health agencies.

The final market in the New Orleans area is concentrated on the Westbank (i.e., across the Mississippi River from the city of New Orleans). While the June 30 data supplied by HCFA listed only one local proprietary agency on the Westbank, research indicates that at least one other Medicare certified agency was present, a hospital-based agency that opened in March. In addition, it was reported that other hospitals on the Westbank had signed agreements with a New Orleans-based agency to have that agency act as their home health arm. Further, information provided shows that the recent opening of the hospital-based agency has severely affected the market share formerly held by the proprietary agency.

The scene described above is that of a dynamic, growing market. While the number of agencies may continue to grow in the short term, one would expect considerable agency turnover, as new entrants replace those that will likely fail.

3.5 Nature of Competition

Agencies in New Orleans first and foremost compete for patient referral agents. Until recently, this competition was mainly for the hospital discharge planners. However, agencies in the area seem to recognize that if they want to survive as more hospitals open their own agencies or joint venture with other groups, it is necessary for them to compete one step back in the referral process, namely for the physician.

All of the agencies spoken to stated that they had begun to aggressively market for direct physician referrals. A variety of techniques were being used including direct mail solicitation, presentations at medical society meetings, and advertising in professional journals. Some agencies stressed the value of follow-up on current patients to get physicians to recognize the need for and value of home health care and to specifically request a particular agency. Marketing of discharge planners has subsided considerably and is now limited to occasional phone calls and mailings. One hospital-based agency reported that they were marketing directly to the public via radio advertisements and bill

boards. It was reported by several sources that some agencies are offering inducements for additional referrals. Rumors heard included free trips to New York and new cars being offered for every "X" number of patients brought into the agency by nurses.

Currently, approximately 75 percent of referrals to home health agencies are made directly by the hospital discharge planner, according to agencies interviewed. In Louisiana, evidence showed that while many of these referrals were from discharge people at acute care community hospitals, a considerable portion of referrals in the New Orleans area are coming from rehabilitation facilities. In addition to the discharge planners, physicians direct to home health about 10 percent of the total patient load seen by local agencies.

Referral sources using local agencies reported that for routine care, they rotated through a panel of available agencies. For more complicated cases, they would select an agency that they feel handles that diagnosis well or provides needed specialized services, such as IV therapy. Hospital-based agencies receive most of their referrals from their own discharge planners and attending staff. In addition, they also accept referrals from other sources as is indicated by public advertising campaigns. Several sources related that hospital-based agencies in hospitals with financial problems were still receiving many referrals and in contrast to the hospital itself, were financially healthy.

Provision of quality services was cited by both agencies and referral agents as the most important factor in attracting and maintaining a share of the home health market. All agencies participated in at least the Medicare required quality assurance and in-service programs. Some agencies did report going beyond the basics to include such mechanisms as annual mail surveys of patients and physicians.

Two other factors were mentioned by all interviewees as important in attracting clients: timely availability and location. Availability includes having 24-hour on-call capability, not just an answering service. It also includes the promptness with which an agency can respond to a request for service. In one area visited, the discharge planner preferred that the agencies visit and acquaint themselves with the patient prior to the patient's release to home care. Related to availability is location. There is a desire in the various New Orleans market areas for a home health services provider to have a knowledge of the community and a local presence there. Some discharge planners favored agencies which served the less desirable areas, such as the Projects and more distant, less populated towns.

Other factors cited as being important in attracting referrals to an agency were:

- Reliability - providing service when expected and on a regular basis;

- Reputation - this includes the knowledge of referral sources about the agency and its strengths and the length of time the agency has served the area.

Range of services did not seem to be an important factor in the New Orleans market. This could be because all agencies interviewed, with the exception of the local government agency, provided the same set of services. Likewise, provision of specialty services also was not a major factor here. Few agencies spoke of providing "high tech" services and only one agency reported that it had begun to advertise itself as a specialist in rehabilitation.

Agencies and others familiar with home health in Louisiana and New Orleans stated that price played no role in competing for publicly-insured (i.e., Medicare and Medicaid) patients. Only one agency, which had a large continuous care side, reported that price of service was somewhat important on the private side. However, the agency charged privately insured patients the same as it did Medicare and Medicaid.

3.6 Price Variation Among Home Health Agencies

Primarily because of the dominance of Medicare and Medicaid, price competition does not exist among agencies in the Louisiana home health market. Maximum reimbursement rates (limits) by type of visit are set in advance by HCFA and specified, usually annually in July, in the Federal Register.

These "caps", however, do not preclude actual charges per visit from differing significantly.

Exhibit 3-3 shows the average charges reported by visit type for agencies in the New Orleans area, along with average Medicare cost limits of these agencies. Medicaid reimbursement rates are same as Medicare, for services covered by Medicaid. Because Medicare establishes a single maximum allowable cost for each type of service which can only be adjusted for location and fiscal year (see explanation in Chapter 1), Medicare limits across agencies are all about the same within a visit type (with the exception of hospital-based agencies). Exhibit 3-3 appears to demonstrate that charges do vary by agency type; however, because only two government agencies and one hospital-based agency were available for analysis (in comparison to 11 proprietary agencies) these differences may be more due to small sample size than actual fact. Proprietary agencies' charges for all services were highly variable, with charges for nursing visits ranging from $35.91 to $100.00, physical therapy, from $35.90 to $99.95, and home health aide services, from $20.57 to $99.98. The highest charges were made consistently by the newest agencies, reflecting their provisional rates.

Most agencies were operating under their Medicare cost limits. One exception was the state-sponsored agency. Officials from state-sponsored agencies stated that their per visit costs often exceeded "caps" because: 1) they treated most of the non-

EXHIBIT 3-3

RANGE AND WEIGHTED AVERAGE CHARGES TO MEDICARE
BY TYPE OF SERVICE AND TYPE OF AGENCY
NEW ORLEANS, 1983
(IN DOLLARS)

TYPE OF AGENCY	TYPE OF SERVICE							
	Skilled Nursing		Physical Therapy		Home Health Aide		TOTAL	
	Range	Avg.	Range	Avg.	Range	Avg.	Range	Avg.
Government(2)	34.13- 56.00	35.87	N/A		27.15-45.00	31.17	32.81-51.20	34.86
Hospital-Based (1)	46.09- 46.09	46.09	50.10-50.10	50.10	32.82-32.82	32.82	41.59-41.59	41.59
Proprietary (11)	35.91-100.00	46.80	35.90-99.95	45.05	20.57-99.98	38.50	28.43-99.92	42.37
TOTAL (14)	34.13-100.00	46.05	35.90-99.95	45.55	20.57-99.98	37.93	28.43-99.92	42.12
Medicare Limits	47.68		46.70		34.54			
Medicaid Rates	47.68		46.70		34.54			

Source: HCFA, unpublished data.

paying, medically indigent population; and 2) for some services, such as medical social services, travel times were great because only a few individuals provided these services for the entire state.

Few agencies could provide information or insight into how the costs of a visit are apportioned over major cost categories. Those agencies that could provide data reported that 65 to 75 percent of costs were labor-related, much of this in salaries. Few agencies, with the exception of the hospital-based and government based agencies, used all salaried staff. Most agencies employed only nurses and home health aides. All other services were provided on a contract basis, often with several agencies having contracts with the same person to provide services.

Overhead was also a significant component of the per visit costs, accounting for about 25 percent of the total. Transportation, medical supplies and pharmaceuticals contributed the remaining costs.

Agencies did comment on Medicare reimbursement levels for the various home health services. Despite some agencies average costs being far above the caps, the majority of agencies felt that reimbursement was adequate. One exception noted by freestanding agencies was that reimbursement for therapists (i.e., physical, occupational and speech) was inadequate. A shortage of these personnel exists in the area. Agencies, as noted above, usually

contract for service provision with these people. Because of the shortage of therapy personnel, compensation rates for total per visit costs, which includes patient contact, travel and documentation, often exceed the Medicare limits.

No dual pricing of home health services was evidenced in the New Orleans market. Almost all agency revenue was derived from the Medicare and Medicaid programs which dictated the administrative and fiscal policies for all agency business. Thus, agencies used the same charge levels in their limited private market as they did in the public.

3.7 Home Health Agency Use Patterns

The distribution of home health services, provided by agencies in New Orleans, by type of service was shown in Exhibit 3-1 and is expanded on in Exhibit 3-4. Services are concentrated in three areas: skilled nursing, physical therapy and home health aide. In fact, these three service groups account for almost 100 percent of all services provided for all agencies reviewed in the New Orleans area. The proportion of home health aide services provided surpasses skilled nursing, with the exception of governmental agencies. Physical therapy services are also significant, accounting for 20 percent of all visits. This statistic confirms what many agencies said about the importance of referrals from rehabilitation facilities in their total business.

EXHIBIT 3-4

DISTRIBUTION OF VISITS BY TYPE OF SERVICE
AND TYPE OF AGENCY
1983

NEW ORLEANS

	AGENCY TYPE		
TYPE OF SERVICE	Government	Hospital-Based	Proprietary
Skilled Nursing	78.1%	35.8%	28.1%
Physical Therapy	N/A	19.6	20.3
Speech Therapy	N/A	2.2	1.9
Occupational Therapy	N/A	0.8	1.1
Medical Social Services	< 0.1	0.8	0.4
Home Health Aide	21.9	39.9	48.1
Other	N/A	0.9	< 0.1
TOTAL	100.0%	100.0%	100.0%
Total Number of Visits	3,780	16,306	142,250
Total Number of Agencies	2	1	11

N/A - Agency does not provide this service

Source: HCFA, unpublish data

It appears that speech and occupational therapy, and medical social services were seldom provided.

According to both agencies and referral agents, DRGs have had no noticeable impact on the volume of patients being seen or mix of services provided. Recent changes in volume were attributed to the introduction of hospital-based agencies and hospital joint ventures in the area. Agencies did, however, report that the patients they were seeing were, upon initial presentation, sicker than in the past, but this was not linked, in their view, to the introduction of DRGs in the hospital.

DRGs did, however, affect activities of the referral agents seen. While they reported that they were not referring any more patients for home health, they were now required to review every Medicare case for possible discharge to home health. This obviously has implications for future home health utilization. As hospitals are forced to cut lengths of stays, and since everyone is being reviewed, more patients will become "appropriate" for home health services.

An additional factor that may be responsible for increased home health care use are the agencies themselves. As the number of agencies expands and they increase their marketing activity, particularly to physicians who may not have referred patients for home health care previously, use of services can expand. This has occurred and may continue to occur in the New Orleans area.

3.8 Reactions to Medicare and Medicaid

Agencies in the New Orleans area made numerous criticisms of the public payors they dealt with, many of which can be traced back to the statutes and their interpretation. Few comments were heard about payment levels for service categories, even for Medicaid, since it reimburses at the same level as Medicare. The only comment consistently made about Medicaid was that eligibility approval under the system took too long, often not being received for more than 30 days after service was requested.

Agency comments appear to fall into two broad categories: problems with the overall Medicare home health benefit program; and problems that are specific to the state and the designated intermediary.

One source summed-up the program problems in the statement, "They [the federal government] are liberalizing home health care by statute and squeezing it by regulation." He went on to say that with each successive session of Congress, more people are brought into the home health care system, but at the same time, the interpretation of previous legislation restricts their ability to provide adequate and quality service. Agencies feel strapped by the "intermittent rule" and feel that it is not sufficient for good patient care.

Another issue raised by agencies was that of the claimed unfairness of many of the retrospective denials. Many said that program guidelines changed too rapidly and constantly, often being applied to services that were provided prior to guideline changes. Related to this are the technical denials (i.e., payment denials made by the Medicare intermediary on non-covered services which are not appealable by the agency). Many thought these totally unfair for two reasons: 1) no appeals are permitted by the agency on technical denials; and 2) they are being used to invalidate the entire scope of treatment when a medical denial is made on one part of the treatment, even when the rest of the treatment can be shown to be medically necessary.

In addition, there was a general sense that the current system allows some agencies to take advantage of the program. First, because there are no standardized instructions or interpretations of the regulations, agencies, to a limited extent, can search for the most lenient intermediary. Since there does not appear to be any sharing of information about agencies among the intermediaries, an agency in trouble with one intermediary can move to another intermediary and have a "clean record". Further, the reimbursement system for new agencies provides great opportunities for "gaming" the system. Stories were told about one agency in the area that, when asked to settle with the government after two years under a high and self-beneficial provisional rate, declared bankruptcy and closed its doors. It

then moved across the street and reopened under a different administrator, using a different intermediary.

State-specific problems related to problems in certification and payment. Agencies were upset that while the State certifies agencies, it did not provide them with the Medicare Home Health Agency manual until they attended the billing seminar. Since the seminar often took place up to three months after certification, agencies felt that receipt of the manual was late and precluded them from billing the intermediary from the start.

Additional problems specifically identified regarding the intermediary have to do with payment. Many agencies claimed that the intermediary was very slow in paying. In addition, one agency complained that benefits were often denied to them because it had taken too long for the agency to submit the claim (agency had a strictly manual billing system).

A final complaint about the intermediary was that it did not seem to have any way of checking on the status of a claim. Agencies reported that if they wanted to know about a claim they were required to re-copy the entire record in question and resubmit it to the intermediary. If, subsequently, another status check was made by the agency, they again had to copy the record and send it to the intermediary. The result was a lot of lost time and high copying costs.

3.9 Reactions to Competitive Bidding

Reaction to competitive bidding for home health services in the New Orleans area was less than favorable. Firstly, agencies had a hard time grasping the concept of competitive bidding. HMOs and PPOs are non-existent in the New Orleans area. While more and more agencies are entering the home health market daily, home health agencies are not tuned into price competition or competitive purchasing approaches.

On the positive side, agencies felt competitive bidding would reduce the number of agencies, eliminating the marginal ones and allowing the financially healthy ones to survive.

Agencies and others interviewed more commonly expressed downside risks and fears of competitive bidding. Some felt that it just would not work. Consistently, it was said that the large existing proprietary agencies would win and that small agencies would be driven out of business. New agencies would be unable to enter the market after the first round of awards. Agencies that did bid would purposely underbid to get the business and then cut services or substitute lower skilled personnel in order to maintain a profit. One group responded that physicians in the area would never tolerate competitive bidding for home health services because the award would remove the physician from the treatment decision process.

Finally, it was felt by some agencies that competitive bidding for home health services would not succeed in Louisiana. Agencies expressed concern over the possiblity that awards in the state would be based on graft, kickbacks and under the table deals, rather than on the stated evaluation criteria of the RFP.

Should awards be made, agencies generally felt that, in the long run, patient care quality would drop dramatically. If the bid was based on price alone, incentives would not exist to provide the same level of services as was provided prior to competitive bidding. Agencies recommended that while quality could not be assessed directly, certain factors should be presented and assessed to attempt to assure quality. Among these were:

- Length of time providing service in the area
- Personnel qualifications
- Agency organization
- Critique by intermediary
- Range of services offered
- Ability to provide service in a timely manner.

In addition to quality declining over time, agencies felt that HCFA's desired end result would not be achieved through competitive bidding, i.e., costs of care would not be reduced. Once the smaller agencies went out of business, the winning

agencies would feel free to raise their prices; hence, costs would not be reduced, only delayed.

As to the question of whether a single agency in the area could assume all the Medicare and/or Medicaid home health business, responses were mixed. Even in agencies that responded positively, there was a question of why one would want to do that. It was felt that while there may be some benefit to the federal government in doing that, it would work to the detriment of the industry and, more importantly, to the patient.

3.10 Other Payment Mechanisms

Agencies in Louisiana did not complain about the current cost reimbursement system. However, when asked about possible alternatives other than competitive bidding, several options were suggested. Primary was some type of prospective payment system. Agencies expressed a preference for something simpler than the current system, which included incentives for profit. It was suggested that the unit of payment should be either per visit by type of personnel or per hour based on aggregate costs. Diagnosis-based reimbursement, such as in Medicare's DRG system, was not encouraged because respondents felt that such a payment system could not take into account differing home environments of the patients.

Two other payment systems were presented by agency personnel. Under one, payment would be based on a percentage of the cost cap, with caps being updated on a regular basis (i.e., a fee schedule approach). More dramatic is the other suggestion: keep the government out of home health: the government advocates a free market in which prices should be set by competitive market forces. The impact on Medicare and Medicaid costs of paying agencies whatever they charged was not addressed by the proponent of the "free market" plan.

3.11 Sources of Information

In the New Orleans, Louisiana area the following sources were interviewed in order to form a picture of the home health market:

- Staff member, Blue Cross of Louisiana
- Staff member, Louisiana Medicaid
- Staff members, Medicare Intermediary (Blue Cross of Louisiana)
- Assistant Director, Division of Licensing and Certification, Louisiana Department of Health and Human Resources
- President, state home health association
- Directors and administrators of six local proprietary home agencies
- Administrators of two governmental home health agencies
- Directors of one hospital-based home health agency
- Discharge planners at four hospitals.

In addition, we received costs and utilization figures from Medicare and Louisiana Medicaid, and cost reports for most of the agencies visited. We were also provided with copies of current and recommended revisions of state home health agency regulations.

4. BOSTON, MASSACHUSETTS

Prepared by:
Christine Bishop and Marc Cohen

4. BOSTON, MASSACHUSETTS

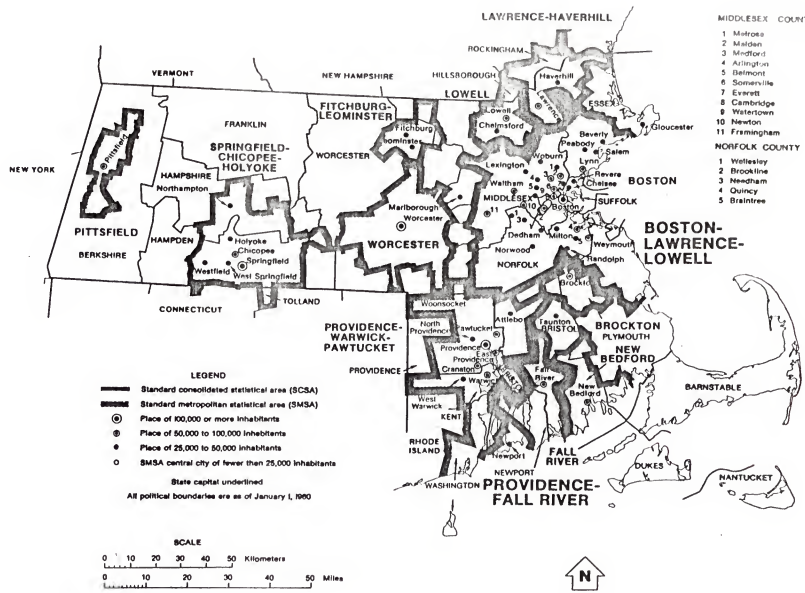
4.1 The Economic, Demographic and Health Care Environment

The Boston New England County Metropolitan Area (NECMA)* incorporates a semi-circular area of 2,428 square miles bounded on one side by the Atlantic Ocean. It includes parts of Essex, Middlesex, Norfolk and Plymouth Counties, and all of Suffolk County (see map on following page). Historical development has resulted in a relatively small center city (Boston proper, the capital city of Massachusetts) surrounded by numerous smaller cities and towns with various degrees of urbanization. As is characteristic of New England townships, these geographic divisions have been in place for hundreds of years, and cover the entire metropolitan area. This means that every portion of the Boston metropolitan area is identified as a part of a particular city or town, an important fact in determining market definition for the traditional home health agencies, which are township-based.

The metropolitan area is served by a network of circumferential and "spoke" highways, making many outlying areas

*In New England, metropolitan statistical areas are defined in terms of cities and towns rather than counties. The NECMA is the equivalent of an MSA in that it must contain one city with 50,000 or more inhabitants and a total population of 75,000.

MAP: BOSTON AREA



accessible by car both from parts of the center city and from other suburbs. Public transportation connecting suburbs to the center exists in the form of commuter trains, but is not notably effective in linking suburbs to each other or to residential areas of the center city.

The Boston NECMA is the twentieth largest metropolitan area in the nation, and the largest in New England. The population numbered 3.7 million in 1983; 12.2 percent of the population was 65 years of age or older, a higher proportion than for the United States as a whole. Employment in white collar and light industry takes a disproportionate share of area employment. Boston's numerous educational institutions are both a source of community pride, and major area employers.

Boston area hospitals and medical schools have a long and eminent tradition. The 54 hospitals in the area serve the population with 3.7 beds per thousand population. Three major medical schools and their teaching hospitals carry out research and professional training, and care for patients from around the world. In part, because of the prestige and success of the medical education institutions, Boston is very attractive to physicians, with a rate of 2.9 patient care physicians per thousand population, a significantly greater supply than in most other cities. The supply of nursing home beds is 58.9 per 1,000 persons age 65 and over.

The political climate of the area has engendered relatively generous support for human services, including health care for those in need. While this has encouraged growth of the health sector, it has also led to public scrutiny and regulation of health sector growth and expenditures. A major new development on the health scene is the rapid growth of health maintenance organizations, both staff model plans (including the Harvard Community Health Plan, with well over 100,000 members) and numerous independent practice association (IPA) plans.

4.1.1 Historical and Regulatory Environments

Against this background, several factors that shape the market for home health care in Boston should be considered, namely the historical development of the market and regulatory factors influencing the market.

Historical Development. The New England tradition of local philanthropy and town responsibility for local welfare, which dates back to the "gathering" of each town as a parish in the 16th and 17th centuries, is embodied in the most prevalent type of home health agency in the region, the visiting nurses associations (VNAs). Each VNA sees itself as responsible for the care of the sick and infirm in its town, and relies to a varying degree on local philanthropic support, as well as on third-party payments.

The strength of the VNA tradition in Massachusetts is the

key both to understanding the current geographic breakdown of the home health market and the flow of home health referrals. This pattern has only recently been challenged. Prior to 1981, Medicare regulations did not permit the certification of proprietary agencies unless they were licensed by the states; since Massachusetts does not license home health agencies, proprietary agencies were precluded from participating in Medicare. The few for-profit agencies in the Boston area filled the only role open to them in the Medicare home health field, as subcontractors to non-profit providers. When Medicare certification requirements were changed (Omnibus Reconciliation Act of 1981) to allow proprietary agencies not licensed by states to seek Medicare certification, a number of new and established proprietary agencies began to provide Medicare home health services directly. However, because of the prominence of the traditional VNAs, the proprietary agencies have yet to capture a significant share of the Boston home health market.

A second challenge to VNA hegemony is now emerging from area hospitals. Although Massachusetts hospitals are currently waived from participating in the national Medicare prospective payment system (DRGs), the all-payor hospital budget system instituted as the HCFA-waivered substitute for its prospective payment system (known as Chapter 372) contains at least some similar incentives to reduce acute hospital length of stay and to expand non-inpatient services. As in other areas of the country, this has led to an increasing interest on the part of hospitals,

individually and through the Massachusetts Hospital Association, in diversifying into long-term care. A hospital home health care department, reimbursed by Medicare on a cost basis rather than under the acute-care limited budget of Chapter 372, could, in theory, add to hospital revenue, reduce hospital inpatient costs by shortening length of stay, and have no negative effect on hospital inpatient revenue. In the past, the Medicare limits have deterred the development of hospital-based home health in Massachusetts. The current hospital reimbursement climate may be enough to overcome these barriers, and, at the least, appears to be fostering new arrangements between hospitals and free-standing home health agencies.

A third aspect of the Massachusetts environment, of less importance in considering the Medicare market, is the expansion of the definition of home care services provided by the Massachusetts Division of Elder Affairs (DEA) through Home Care Corporations (HCCs).

Massachusetts has been one of the most active states in supporting chronic community-based care for the elderly under Title XX; while the funding of this program has recently shifted to 100 percent state funds, the commitment remains strong. A long-standing tension exists between the homemaker and chore services provided by the designated HCCs in each DEA area and the medically-oriented skilled nursing and related services provided by home health agencies under Medicare and Medicaid. Depending

on eligibility, these organizations can serve the same elderly clients, perhaps at different points in the course of their disability and recovery from acute illness episodes. Recently DEA has added a personal attendant service that can be provided by the HCCs; there is little clear distinction between this service and the services provided by (more expensive) certified home health aides. The HCCs do not provide skilled nursing services, and are not certified for Medicare services; however, they are now seen as potential competitors to home health agencies that are active, or considering entry, in the chronic-side of home-delivered disability related services. Especially because of Massachusetts' relatively extensive Medicaid coverage of chronic home health services, participation or exclusion from the chronic-care portion of the market may affect the viability of some agencies.

Regulatory Environment. Home health agencies need not go through a licensure process in order to provide home health services in Massachusetts. However, they must be certified as meeting Federal requirements and standards if they are to provide Medicare or Medicaid home health services. This means that those agencies who care exclusively for private pay patients are completely unregulated. For those agencies that provide care to Medicare/ Medicaid patients, as well as to private pay patients, the Division of Health Care Quality in the Massachusetts Department of Public Health determines compliance with the federal regulations and approves or rejects certification of agencies.

To achieve certification an agency is required to submit a report that shows it is able to comply with the regulations. The Division of Health Care Quality then conducts an inspection of the agency, usually within one month of the agency's request for certification. Upon completion of the inspection, the surveyor submits a deficiency statement to the agency (when needed) and the agency is required to present a plan of corrections. This is then submitted to the Department and, depending upon the nature of the deficiency, certification is granted or another on-site visit is made with a final decision made subsequent to the inspection.

4.2 Definition of the Market: Geographic

Agencies differed in the geographic definition of their markets. The VNAs consistently focused on home health patients within specific geographic areas generally in the township in which they were located, while the proprietaries identified patients throughout the entire metropolitan areas as their target population. Two of the VNAs interviewed took traditional VNA approaches to the market, with the goal of serving a specific town's home care needs. These agencies did reach out to serve patients in neighboring areas, but under-played this to their community boards and sources of philanthropy. Some VNAs have consolidated the activities of groups of local associations, to range over several towns; one of these appears to define its market substantially by the hospital it is associated with, which draws patients from several nearby towns.

The proprietary agencies described their market as the entire Boston area. Because of their relationship with personnel throughout the area, and the relatively good network of highways in the Boston area, they reported that they are able to serve patients in locations throughout the Boston NECMA. As competition increases for home health care services with the entry of additional proprietary and hospital-based agencies, we may see the VNAs increasingly compete in nearby townships and possibly throughout the Boston metropolitan area.

4.3 Definition of the Market: Cost and Utilization

It is extremely difficult to gather reliable statistics on home health care utilization and cost for any market area. While data on Medicare expenditures and visits are collected, and similar information is usually available for Medicaid, information on private pay, private insurance, and free care is not easily available. In the section below, aspects of home health care used by Medicare, state-funded (Medicaid and other), private, and indigent patients are considered.

4.3.1 Medicare's Market Share

As in other parts of the country, Medicare covers a substantial share of the home health care provided by certified home health agencies in the Boston area. For those agencies interviewed, Medicare represents from 38 to 90 percent of their caseload.

On a local level, in 1983, Medicare charges for home health care in the Boston area totaled $35.9 million, an increase of 96 percent since 1981. Based on the limited information available on home health care expenditures by other payors for the Boston area, discussed below, Medicare payments represent about 60 to 80 percent of total home health agency revenues in 1983.

Medicare-certified agencies provided a total of 1,054,938 visits to Medicare clients in 1983. As shown in Exhibit 4-1, the total number of visits has been rising steadily in Boston, increasing by 62 percent from 1981 to 1983. At the same time, the mix of visits has been shifting slightly. The proportion of skilled nursing visits has dropped from 48.6 percent of the total number of visits in 1981, to 42.1 percent in 1983. Concurrently, home health aide services has increased by 6 percent. No real changes are observed in the therapy visits combined.

4.3.2 Medicaid: A Significant Proportion of Use in Massachusetts

The Massachusetts Medicaid Home Health Program is one of the largest in the country. In FY83, it was the third largest in terms of the number of recipients served - 20,832, and ranked second in expenditures - $16.7 million. Massachusetts contained nearly 5 percent of all Medicaid home health recipients and its expenditures accounted for nearly 3 percent of the total throughout the United States. Medicaid expenditures specifically

EXHIBIT 4-1

NUMBER OF VISITS BY TYPE OF SERVICE
BY YEAR - MEDICARE
BOSTON

TYPE OF SERVICE	YEAR					
	1981		1982		1983	
	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total
Skilled Nursing	317,094	48.6%	385,418	44.3%	444,369	42.1%
Physical Therapy	75,485	11.6	96,646	11.1	120,418	11.4
Speech Therapy	10,089	1.5	12,803	1.5	13,166	1.2
Occupational Therapy	8,279	1.3	12,649	1.5	18,172	1.7
Medical Social Services	3,621	0.6	7,681	0.9	10,278	1.0
Home Health Aide	237,963	36.5	354,333	40.7	448,371	0.1
Other	231	< 0.1	126	< 0.1	164	< 0.1
TOTAL	652,762	100.0%	869,656	100.0%	1,054,938	100.0%

Source: HCFA, unpublished data.

for the Boston metropolitan area cannot be identified. If Medicaid home health care expenditures were distributed among areas in Massachusetts proportionately to population, FY83 expenditures in the Boston metropolitan area would be $10.7 million. The importance of Medicaid was also revealed in interviews with the agencies, which indicated that Medicaid cases were between seven and 48 percent of the caseload. On average, Medicaid expenditures may represent 15 to 25 percent of home health agency revenue.

In addition to the traditional home health care services, Massachusetts Medicaid has requested and been granted waivers to provide less skilled services under the "2176" Home and Community Services program. As of November 1, 1984, three requests had been approved by the Secretary of Health and Human Services. The first waiver that was approved enabled Massachusetts to provide to the aged and disabled, respite care and a personal emergency response system. The waiver did not apply to the entire state, but, rather, to only two communities: Framingham and Beverly.

A second waiver for services, to be provided statewide and jointly administered by the Department of Elder Affairs and Department of Public Welfare, was also approved for the elderly and disabled above the age of 60. Social services, day care, respite care, personal care and case management services are covered by the waiver.

The third waiver, approved in May 1984, is designed for the retally retarded. This waiver permits the Department of Mental Health to place the developmentally disabled in group residential homes with personal care services, transportation, treatment, case management, dietary and other services. The waiver has been approved on a statewide basis.

4.3.3 Other State Funding of Home Care Services

Massachusetts has been generous in funding home care services for the elderly disabled, working through the state's Department of Elder Affairs. Home care core services include information and referral, case management, homemaker services, chore assistance, home delivered meals, transportation, companionship, and laundry services. Although these DEA home services are now used to complement Medicare and Medicaid skilled services, the twenty-three home care corporations created to provide DEA services are seen as potential competitors for home health agencies providing chronic homemaker/home health aide care.

These services are provided free to SSI recipients who are 60 or above, and a means test is employed for other elders 60 and above. In June 1984, the number of people authorized to receive specific services in Massachusetts included 36,474 for homemaker services, 6,111 for home delivered meals, 4,527 for chore services, and 495 for laundry services. The number of people who

actually received the service was approximately 10 to 15 percent less than the numbers of people authorized.

4.3.4 Private Insurance and Self Pay

Blue Cross contracts with VNAs to provide intermittent skilled nursing and physical therapy to patients with basic Blue Cross insurance. These contracting arrangements, which began in 1957, are now being opened to proprietary agencies. In addition, patients with Major Medical coverage can receive a wider array of home care services from VNAs meeting certain size and service availability and having contracts with Blue Cross (known as Coordinated Home Health Care contracts). Many commercial health insurance companies are now also providing home health benefits.

Health maintenance organizations are providing health services, including home health, to an increasing proportion of the Boston-area population under-65, and are expected to compete to enroll Medicare patients under newly promulgated HCFA regulations. The largest HMO in the area, Harvard Community Health Plan, contracts with on proprietary home health agency to provide covered services. A staff-model HMO recently opened by Blue Cross in the Boston area contracts with a group of VNAs to provide home health care to members. The home health services provided to HMO members are not yet an important part of the total market, but have the potential to become so with growth of area enrollment, especially of the Medicare-covered population.

Thus the HMO presence in the Boston market is more important than its current market share would indicate.

The proportion of Medicare certified agency revenue derived from self pay patients and those with private insurance is unknown. However, several agencies reported that their private pay business represented 12 to 15 percent of their total business.

4.3.5 Uncovered Care

Some home health care patients are not eligible for covered care under public programs or private insurance, while others exhaust their coverage or lose their covered status. The treatment of patients who lose their coverage under Medicare or Medicaid differs by agency type. Proprietary agencies reported that they try to transfer patients to the private side of their business. If these patients cannot afford to pay themselves, they are either referred back to the original referral source or to charitable organizations or churches. In some cases, they are referred to VNAs.

The VNAs interviewed reported that they offer care on a sliding fee schedule or on a no-pay basis to patients not covered by any insurance or public program. However, VNAs stated that delivery of free and partial-pay care has become increasingly difficult in the absence of specifically designated philanthropic

funds. This is because Medicare and Medicaid reimbursement, based on average per visit costs, prevents shifting of the cost of free care onto these payors. Only one agency, backed by a specific local charity group, reported significant free care. Others reported partial-pay patients as private-pay. Limited information, drawn from agency annual reports, reveals the extent of subsidization of private pay patient's costs by local philanthropy. The value of free care for agencies for which data were available varied from 3 to 8 percent of total agency revenue. Much of this care is paid for by the United Way.

None of the proprietary agencies interviewed offered care on a sliding-fee basis, but one had an arrangement with a hospital-based charitable fund that again indicates that free care can be delivered if it is specifically and directly supported. The agency contracted to care for non-paying patients referred by the hospital, and agency charges were paid by the charitable trust.

4.4 Market Concentration

According to the HCFA listing of Medicare providers, there were 60 home health agencies certified to provide Medicare services in the Boston metropolitan area as of June 30, 1984. Of those agencies, 30 were visiting nurses associations, five were other voluntary agencies, eight were hospital-based agencies, ten were proprietary agencies, three were private non-profit agencies, and four were local government agencies.

These agencies compete for patients in differently defined markets, so that their estimates of the proportion of the patients they serve in their own self-defined market must be used with care. First, it is important to recognize that agencies do not actively seek out Medicaid and partial-pay patients, whose care costs more than the revenue it generates. Proprietary agencies serve few no-pay or low-pay patients, and some do not participate in Medicaid.

In all cases, the local VNA appeared to be the dominant provider in each town, with market shares estimated as high as 95 percent. Several of the VNAs in townships in the Boston suburbs that did not merge with other nearby VNAs were losing market shares to near-by consolidated VNAs, products of mergers, and possibly also to proprietary and hospital-based agencies. Market share data for the entire Boston metropolitan area are shown in Exhibit 4-2. The five largest agencies in terms of visits and charges were all VNAs. These five agencies made up 44 percent of all Medicare visits in the Boston NECMA in 1983, and 48 percent of the charges.

As the number of agencies has increased, the VNAs hold on the market has begun to slip. Between 1981 and 1983, the VNA share of Medicare payments declined from 84 to 81 percent, while the share of proprietary and private nonprofit agencies increased from 0.5 percent to 3.8 percent. During this two year period, hospital-based agencies increased their share of Medicare revenues

EXHIBIT 4-2

BOSTON
MEDICARE MARKET SHARES OF BOSTON
HOME HEALTH AGENCIES
1983

	Visits		Charges	
TYPE OF AGENCY	Number	Percent of Total	Dollars	Percent of Total
VNA	239,145	22.7%	$ 9,946,251	27.7%
VNA	72,087	6.8	2,321,582	6.5
VNA	53,283	5.1	1,761,313	4.9
VNA	52,515	5.0	1,558,782	4.3
VNA	50,097	4.7	1,549,116	4.3
TOTAL 5 AGENCIES	467,127	44.3	17,137,044	47.8
TOTAL ALL AGENCIES	1,054,938	100.0%	$35,869,507	100.0%

Source: HCFA, unpublished data

from 8.4 to 9.4 percent. The Medicare market share for other voluntary and government agencies remained stable at 6.7 percent over the period.

4.5 Nature of Competition

Interviews with agencies revealed that home health agencies compete intensely for control of patient flow. This does not occur around price or cost of care. What might be called "professional working relationships" appear to be most important in determining which agencies receive referrals.

Home health agencies attempting to serve Medicare patients must reach one of two key decision makers over home health consumption decisions: the hospital discharge planner or the physician. The typical VNA interviewed received about 75 percent of its admissions through discharge planners, often from one nearby hospital with which the VNA had a long-established working relationship. While the proprietaries also gain referrals from discharge planners, several had much greater patient flows directly from physicians. Direct referral from patients and their families was not common.

In seeking referrals from discharge planners and physicians, agencies do not compete on the basis of price or cost. Instead, both agencies and hospital discharge planners cited response time, quality of care, follow-up with referral

sources, and long-standing working relationships as factors in gaining referrals.

Discharge planners reported that ease of referral was, in many cases, the most important issue in selecting an agency: Was the agency easy to reach, available to serve the patient when needed, with the services he or she required? Location of the patient was an important determinant of ease of referral in some cases, with discharge planners assigning patients to nearby VNAs based on the patient's home address. If patients have preferences about which agency should serve them, the discharge planner attempts to honor these, but this would usually occur only in the case of a patient with a previous home health care episode or a patient with ties through religious affiliation or community location to a religious or community based agency. If the patient will be directly paying for some non-Medicare services, to discharge planners reported that, they are more likely be referred to a proprietary agency which is able to coordinate homemaker services on its so-called "private side" with the skilled services provided under Medicare.

The Boston market has long been the province of the VNAs, and the working relationships between hospital discharge planners and local VNAs are so well-established that new agencies expressed frustration as they described their attempts to break into the hospital discharge referral flow. Anti-trust suits have been mentioned by the new agencies, as they describe the hospital

discharge market as "locked up" by the VNAs. Yet in the new climate, the long-standing "gentleman's agreements" that protected the local VNA market boundaries are breaking down, and some VNAs now seek expansion in areas once seen as belonging to sister VNAs.

Strategies used to reach discharge planners include:

- written materials describing new services, expansion of services;
- meetings with discharge planners at the hospital;
- close liaison relationships between agency and hospital, e.g. where agency is located on hospital grounds, shares personnel with discharge planning department, or supplies a liaison person to coordinate discharges;
- yearly luncheon;
- educational program on aspects of discharge planning; and
- courier service to pick up written referrals on discharged patients.

In one case, a discharge planner described a proprietary agency promising free care to needy uninsured discharged patients if the discharge planner would refer Medicare patients as well.

Other agencies pursued new working arrangements with referral institutions. Examples of this are presented below:

- One VNA had an interlocking subcontract arrangement with the hospital home care department. The VNA received referrals of patients requiring skilled

nursing, non-intensive physical therapy and home health aide visits; if the patient became sicker and required more intensive services available from the hospital home care unit (IV therapy, physical, occupational, speech therapy), he or she was transferred back to the hospital-based agency for administrative coordination.

- In several instances, agencies had recently, or were about to, become sister corporations with the hospital under an umbrella hospital board. Such an arrangement means that they are not strictly hospital-based agencies, but they are very closely tied to the hospital.

Some competition for referrals is taking place outside the traditional referral route. A new Blue Cross-sponsored closed panel health maintenance organization in the Boston area, Medical East, has contracted with a consortium of VNAs to provide home health services under its comprehensive capitated package. Known as the VNA Coalition, it is a group of approximately 25 VNAs with a single contract with the HMO. A steering committee made up of representatives from eight of the agencies directs the group. Referrals are made through three central intake points and are assigned to a particular agency based on location. The Harvard Community Health Plan has contracted with a single proprietary agency to serve its members when they need home health care. Further, proprietary agencies are seeking business from self-insured local companies. The agencies are seeking to persuade the firms that they can save on workman's compensation if they provide effective home health care to their work force.

4.6 Price Variation Among Home Health Agencies

Medicare, Medicaid, and other payors may pay different prices for care to the same agency. Each of these prices is discussed in turn below.

4.6.1 Variation in the Price Paid by Medicare

Although price does not affect competition among agencies for the Medicare home health patient, there is variation among Medicare-participant agencies in their costs, and thus in the charges made to Medicare. Exhibit 4-3 shows charges per visit by the various types of agencies. This table indicates that charges by VNAs, other voluntary agencies and the private non-profits are close to one another for nursing and physical therapy services. Some disparity is, however, noticed in charges among these agencies for home health aide services. Charges by proprietaries and hospital-based agencies are similar in all categories and are considerably higher than other types of agencies. The higher charges by proprietary agencies may, however, be only temporary - a reflection of large start up costs (none of the proprietary agencies was in existence before late 1981).

The effect of these different charges on the price that Medicare actually pays may be somewhat limited because Medicare payment may not exceed pre-determined cost limits. Information provided by the agencies indicated that two out of the three

EXHIBIT 4-3

RANGE AND WEIGHTED AVERAGE CHARGES TO MEDICARE BY
TYPE OF SERVICE AND TYPE OF AGENCY
BOSTON, 1983
(IN DOLLARS)

Type of Agency	TYPE OF SERVICE							
	Skilled Nursing		Physical Therapy		Home Health Aide		TOTAL	
	Range	Avg.	Range	Avg.	Range	Avg.	Range	Avg.
VNA (26)	24.39-44.93	35.08	20.58-44.97	33.74	13.74-42.43	29.96	21.10-40.01	32.86
Other Voluntary (4)	29.98-37.24	32.73	29.98-36.84	32.11	15.53-30.16	25.53	25.04-32.08	29.42
Government (2)	24.99-27.00	25.68	28.97-29.95	29.68	10.05-20.96	19.29	21.06-22.88	22.46
Hospital-Based (7)	35.20-91.25	47.43	32.58-93.25	46.36	25.84-53.02	35.36	34.90-67.16	42.98
Proprietary (6)	44.00-66.99	51.85	38.00-66.00	43.44	28.35-67.91	38.50	35.74-67.49	43.27
Private Non-Profit (3)	27.97-40.04	35.45	31.34-50.00	32.26	16.87-26.30	19.49	23.31-33.17	26.03
TOTAL (48)	24.39-91.25	35.85	20.58-93.25	35.19	10.05-67.91	29.68	21.06-67.49	33.27
Medicare Limits	54/65*		52/59*		41/57*			
Medicaid Rates	30		25		11			

*Includes hospital add-on

Source: HCFA, unpublished data

proprietaries exceeded the caps for all of the service categories and the third exceeded them for home health aide and speech and physical therapy. The VNAs all had average per visit costs well below the allowable Medicare limits. The tendency of agencies to keep their costs below Medicare limits may relate to the low Medicaid maximum rates (differences between costs and Medicaid payments do not affect Medicare rates).

The per visit cost computed from available cost reports can be broken down into major categories including, labor, transportation and overhead. In general, labor expenses comprised over two-thirds (69 percent) of per visit costs among VNAs, whereas for proprietaries, labor accounted for only half of the cost. In addition to the expense incurred while spending time with a patient, labor costs include travel time, time needed for documentation of the visit, and time spent in following up with the patient's family, physician, and discharge planner. For the proprietaries, nearly half of the per visit cost could be attributed to overhead; for most VNA's overhead account for only a quarter of the per visit costs. For all agencies, transportation expenses comprised less than 10 percent of the average cost per visit. Medical supplies, pharmaceuticals, and general and administrative costs were considered minor contributors to the entire cost of a visit.

It is interesting to note that two prominent agency types studied in Boston, the proprietary and the VNA, have different

styles of controlling, monitoring, and paying their service delivery personnel. The proprietary agencies operated in a temporary-help agency style, with the central office contracting with individual health personnel from a roster as referrals come in. Agencies reported that most of their contact with personnel could be effectively handled by telephone and mail: nurses received information on patients by telephone, could send changes in doctor's orders to the physician for signature, and could mail in both weekly hours and case documentation. Supervisors coordinated patient services in the field, but might not come into face-to-face contact with the providers when they visited patients' homes. One agency, not fully satisfied with this arms-length relationship with staff, was instituting informal Friday afternoon office-hours, where case coordinators and other administrators would be in the office.

Working from rosters of licensed nurses and home health aides who are interested in providing home health care on an as-needed basis, the proprietary agencies are able to meet changing demands for care in a flexible manner: few, if any, care providers are paid on a salaried basis, or even guaranteed a minimum number of hours per week. After a training and observation period when more steady availability is required, workers can typically choose their own hours of availability from week to week.

The VNAs described a different service delivery style. Most professional nurses were paid on a salary basis. Many agencies reported that significant numbers of their aides were "benefitted" as opposed to being paid as contractors without social security and health insurance. Some paid aides on a salary basis. The VNAs typically expected their nurses to report to the central office each morning to receive, in writing, information on new and ongoing cases. The nurses returned to the office to consult with other staff, allowing face-to-face coordination of various services provided to individual patients and supervision. Paperwork was completed in the office.

Much of the difference between VNA and proprietary agency practices regarding using salaried or contract personnel to provide services may relate to the nature of business. In 1983, the VNAs had average Medicare revenue of over $1 million, while average revenue for proprietaries was about one tenth as large. It may not be administratively and fiscally feasible to employ full time nursing staff with a variable case load and with annual revenues of less than $200,000. In the other market study sites, the staffing and contracting experience of VNAs and proprietaries tended to be similar.

4.6.2 Price to Medicaid: Determination and Variation

Care provided to Medicaid patients is reimbursed at prospective per-visit rates determined by the Massachusetts Rate

Setting Commission. While the rates are based on cost, they entail two provisions which make them significantly lower than cost, only about 50 percent of Medicare limits, for most proprietary agencies. First, nursing costs are assessed for allowability using a productivity standard of 5.2 visits per day per full-time equivalent; an incentive payment allows for sharing the cost-savings of productivity gains above 6.03 visits per day per FTE. Second, overhead costs cannot exceed 37.5 percent of total reimbursable costs, net of transportation. The rate-setting method helps to explain why proprietaries serve very few Medicaid patients. In addition, the rate setting procedures may help to explain why VNAs tend to keep costs well below the Medicare limits: while Medicare costs would be reimbursed up to the limits, this would not be true for Medicaid, and the amount of uncovered expense would increase.

4.7 Home Health Agency Use Patterns

As in other parts of the country, the patients cared for by Boston-area certified home health agencies most commonly make use of skilled nursing and home health aide services. As was shown in Exhibit 4-1, physical therapy visits are also provided in significant amounts by the agencies.

Little information is available on case mix for area home health agencies. With respect to age, proprietary agencies reported that close to 100 percent of their caseload was 65 years

of age or older, not surprising since they serve mostly Medicare clients. The two largest VNAs were able to supply admissions statistics by diagnosis. These data showed that the most frequent diagnoses were those associated with old age, namely diseases of the circulatory system, malignancies and injuries. Agencies have not observed striking changes in case mix due to the Massachusetts hospital budget control measure, Chapter 372. Like PPS, this all-payor reimbursement system is designed to contain hospital costs, but does not specifically target Medicare length of stay for reductions.

A question in considering the competitive bidding options is whether one or several bidding entities could serve the entire area. As the market analysis has shown, the Boston area has many sub-markets, and is large geographically and in number of visits. Yet the mode of operation of the proprietary agencies, with staff paid on a per visit basis and located throughout the area, already allows them to serve patients throughout the area and to expand to meet demand. Geographic coverage accounts, in part, for their contracts with the area-wide insurers, since the alternative would have been for the insurer-entities to contract with numerous individuals VNAs. The VNA Coalition, the group of 25 VNAs described earlier, is a direct response to this capacity of the proprietaries to cover a broad geographic area. Referrals are to be handled at a central location, and patients are to be assigned to local VNAs based on patient's residence rather than hospital of discharge. This would allow for centralized control

of utilization and localized control of quality of care and service delivery.

4.8 Reactions to Medicare and Medicaid

Most agencies interviewed were dissatisfied with certain aspects of the Medicare/Medicaid programs. The problems can be classified in the following way:

a. Policy problems
b. Administrative difficulties
c. Finance-related issues.

More than half of all agencies reporting indicated that the paperwork and documentation required by Medicare/Medicaid was excessive. To highlight the problem, one VNA provided figures showing the amount of time nurses spent in the office on administrative matters. While a nurse might spend 43 percent of her time in a patient's home, more than 45 percent of her time was spent in the office documenting care delivery.

Documentation was given added impetus because of a new method for computing agency eligibility for waiver of liability under Medicare being used by the intermediary in Massachusetts during the last half of 1984. Prior to this time, agencies under this waiver were assumed to act in good faith in delivering care,

so that when claims were denied upon review, care already delivered was still reimbursed by Medicare. Until the summer of 1984, Blue Cross of Massachusetts granted waivers to agencies whose denied visits were less than 4 percent of total visits. The new standard used was that denied visits must be less than 4 percent of the visits reviewed. Because of this change in determination, more than half of the certified home health agencies have lost their waiver of liability. Every case cared for by non-waivered agencies had to be reviewed, rather than just a sample, and the cost of denied visits was not reimbursed by Medicare. Agencies still under waiver reported that their concern about losing their waiver had made them much more hesitant to admit patients whose eligibility for coverage was not clear cut, and had increased the time spent on documenting eligibility. Agencies who lost their waivers had the added concern that denied claims would not be paid. An agency's waiver could be reinstated or denied on a month to month basis. Agencies reported that ongoing concern about coverage had reduced Medicare case loads significantly, and had increased Medicaid and partial-pay patients. Total caseloads appeared to decline in response to this regulatory action. It is expected that since this method of waiver determination stopped being used (effective January 1985) agency patient loads should return to normal.

Payment delays, as well as inconsistent and arbitrary regulations, were mentioned by half of the respondents as additional problems. These problems cause financial strains for

those agencies that cannot finance cash flow during a waiting period. Finally, half of the respondents indicated that Medicaid reimbursement was too low. The proprietaries claimed that reimbursement under both Medicare and Medicaid was too low.

4.9 Reactions to Competitive Bidding

Reactions among agencies to competitive bidding for home health care in the Boston area were mixed. Proprietary agencies tended to be especially favorable to a new selection mechanism which they viewed as potentially ending the VNA hold on the Medicare market. Although proprietary agencies' Medicare charges are higher than VNA charges, they did not appear concerned that this would put them at a disadvantage in competing for Medicare business under new rules. VNAs tend to have concerns about quality and long run costs, but not all VNAs were opposed to the concept of competitive bidding.

Almost all respondents said the number of firms in the market would decline. However, there was some degree of variation in interpreting the likely impact of such a reduction. A number of VNAs and one proprietary agency believed that the system would reduce competition and lead to a monopoly or oligopoly. One VNA director felt that after the system was in place for a few years, collusion among firms would result in higher prices. Another director felt that consumers would suffer because they would be more limited in their choice.

A second view offered by a number of respondents was that a reduction in the number of firms would leave remaining firms with larger volumes. Respondents indicated that average costs would decline as volume increases. Thus, these respondents felt that a reduction in the number of firms would lead to efficiency gains in the market.

While more than half of those responding felt that costs would ultimately decline, two VNAs, as well as one proprietary agency, believed they would increase. The director of one VNA thought that although prices may initially fall, the requirements for stringent quality assurance programs would greatly increase administrative expenses. Another VNA director argued that as the number of firms declined, the incentive for cost cutting would be diminished, and, hence, overall costs in the long run would increase. Finally, the director of a proprietary agency felt that while costs billed to Medicare/Medicaid may actually fall, savings to the system would not be realized. More specifically, he claimed that quality of care under a competitive bidding system will decline, and, therefore, people who might otherwise have stayed out of hospitals will be forced back into them.

The prediction that quality would decline under a contractual bidding arrangement, heard from both VNAs and proprietaries, is somewhat puzzling in light of agencies' general willingness to proceed with contractual arrangements with insurers. Proprietary agencies expressed the belief that Medicare is adequately

assessing quality through its record audits, and there is no reason that this should not continue. Some VNAs expressed specific concerns about whether Medicare has access to the appropriate information to assess quality of care, either for current quality control or to select and monitor winning bidders in a competitive bidding situation.

Who one expects to win bids under a competitive bidding system depends on who is asked. VNAs expect proprietary firms to win contracts, whereas proprietaries think the VNAs will win. Proprietaries claim that the VNAs will win because of their traditional relationships with hospital discharge planners, their high volume which would enable them to submit low bids, and the widespread acceptance of VNAs in local communities. VNAs fear that proprietaries will win contracts because of their experience in marketing and competing, their ability to charge different prices for private and Medicare patients, and their advantage in finance, many times as part of larger corporations.

As noted above, agencies expressed concern that quality of care for Medicare patients could or would decline under a contractual competitive bidding process. They offered few suggestions about improving quality monitoring, either currently or under a competitive bidding arrangement. Four agencies recommended that patients be visited and interviewed by assessment staff to determine quality. Others cited the need for clearer quality standards as well as measurement instruments.

Two agencies felt that a focus on investment in training of staff would be a good method for helping to ensure high quality care. Implicitly, agencies saw the injection of price competition into the home health market as introducing incentives to reduce service inputs.

4.10 Sources of Information

Information was gathered on the Boston home health market from a variety of sources. Most important were interviews with agencies and discharge planners. Specifically we talked with:

- Directors of six Visiting Nurses Associations
- Directors of four proprietary home health agencies
- Director of one hospital-based home health agency.
- Discharge planners at five hospitals.

In addition, the representatives of the following agencies and organizations were interviewed:

- Massachusetts Association of Community Health Agencies
- Massachusetts Blue Cross (intermediary)
- Assistant Director, Massachusetts Rate Setting Commission
- Staff Member, Massachusetts Department of Public Welfare (Medicaid)
- Assistant Director, Massachusetts Department of Public Health (certification agency).

5. CONCLUSIONS AND IMPLICATIONS FOR COMPETITIVE BIDDING

5. CONCLUSIONS AND IMPLICATIONS FOR COMPETITIVE BIDDING

5.1 Introduction

The purpose of this limited market study of the home health care industry is to develop an understanding of its industrial structure, how agencies compete, and other important characteristics of the home health care market. This should assist in not only assessing the feasibility and attractiveness of competitive bidding strategies, but also in designing alternative systems that are most compatible with home health market characteristics and most likely to achieve Medicare and/or Medicaid objectives for home health care procurement. In this section we summarize the primary conclusions of the market study. This is followed by a review of the study's implications for competitive bidding.

5.2 Primary Study Findings and Conclusions

Home Health Care Services - Product Definition.

Home health care might be defined as care provided by patients in their homes, required because of adverse health conditions. This broad definition could include skilled health care services, homemaker type services, durable medical equipment, and other products and services provided to home-bound individuals. For the purposes of this study, a narrower

definition is used. Home health care is defined as those services covered under the Medicare program:

- part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;
- physical, occupational, and speech therapy;
- medical social services under the direction of a physician; and
- home health aide services primarily provided to assist with the patient's personal care, under the supervision of a registered nurse.

While medical appliances and supplies are also covered under Medicare, because of differences in providers and in the nature of the products, these were not considered as home health care services for purposes of this study.

Size and Growth Trends in Home Health Care.

Home health care services represent a small but rapidly growing share of total health expenditures. HCFA does not publish expenditures data separately for home health care. Predicasts, Inc., a market research firm, estimates that in 1983, expenditures for "primary home health care services" were $2.6 billion, or slightly less than 1 percent of personal health care expenditures. However, while relatively small, home health care is growing more rapidly than any other major component of health care expenditures. Between 1979 and 1982, Medicare payments for home health care increased from $520 million to $1,091 million,

an increase of 110 percent over the three year period. Medicaid home health expenditures increased from $263 million to $496 million, a rise of 89 percent. Medicare and Medicaid 1983 home health expenditures are estimated to be $1.5 billion and $600 million, respectively. We estimate that Medicare expenditures represent 60 to 70 percent of total home health expenditures, while Medicaid expenditures represent an additional 20 to 25 percent. Private insurance and consumer out-of-pocket payments represent about 10 to 20 percent of home health expenditures.

The primary factors responsible for growth in home health expenditures are:

- changes in Medicare legislation which relaxed home health care entry requirements;
- a growing proportion of the population that is 65 and over, and especially the population that is 75 and over -- the demographic group that represents the largest users of home health services;
- increased preference of home health services as opposed to inpatient hospital and nursing home care.

The last two of these factors are expected to continue in importance over the next decade. The preference for home health care services will be abetted by pressures under Medicare DRG and other admission-based payment systems, which provide incentives for early hospital discharge. An additional factor is marketing activities directed toward physicians and consumers by the increasing number of home health agencies.

Some measures of home health care growth are:

- growth in Medicare home health visits: 7,654,000 in 1974, to 29,006,000 in 1982;
- growth in number of Medicare-certified agencies: 2,212 in 1972, to 3,689 in 1982, to 5,274 in 1984.
- growth in number of Medicare home health users and users per 1,000 beneficiaries: 392,700 in 1974 to 1,171,700 in 1982, and 16.5 per 1,000 beneficiaries in 1974 to 39.7 in 1982.

The substitution of home health care for inpatient hospital and nursing home care has become a policy objective of Medicare, Medicaid (rationale for "2176 Waiver" program) and increasingly for private health insurers, as well. Home health expenditures are expected to continue growing more rapidly than other health care services, although possibly by less than the 30 percent annual rate of growth observed between 1974 and 1982.

Recent growth in home health visits at each of the three market study sites has been substantial. As shown in Exhibit 5-1, the increase in number of visits between 1981 and 1983 was 129 percent in Sacramento/Stockton, 109 percent in New Orleans and 62 percent in Boston. Each of the visit types experienced large increases, although percentage increases were greater for occupational therapy and medical social services, two of the less frequently used services. Home health visits per person age 65 and over* residing in the metropolitan area doubled in Sacramento/

*The number of persons age 65 and over was estimated by increasing 1980 Census statistics for each metropolitan area by estimated national rates of increase for this age group.

Stockton and in New Orleans over the two year period. In Boston, where the initial rate of usuage had been higher, it increased by about half between 1981 and 1983.

The distribution of visits by type of services is also shown in Exhibit 5-1. At each of the market study sites, skilled nursing and home health aide were the most common types of visits, accounting for 75-85 percent of all visits, although the relative magnitude between the two differed among the sites. Physical therapy, the third most common type of service, varied from 11 percent of all visits in Boston to 20 percent in New Orleans. No other type of visit accounted for more than 3 percent of visits at any of the sites.

Home Health Care Market: Geographic Definition.

The market for home health care is typically a city, its surrounding suburbs, and nearby less populated areas. The market is defined this way for several reasons. Medicare recognizes a provider's service area as being a fifty mile radius around the provider. Also, additional costs (related to travel time) and administrative/quality assurance requirements make serving areas more than one to 1-1/2 hours travel time impractical. Finally, hospital discharge planners prefer agencies with a local presence and knowledge of the local community.

EXHIBIT 5-1

GROWTH IN HOME HEALTH VISITS AT THE THREE
MARKET STUDY SITES, 1981-1983

TYPE OF SERVICE	SACRAMENTO/STOCKTON		NEW ORLEANS		BOSTON	
	Percent Change 1981-83	Percent of Total Services, 1983	Percent Change 1981-83	Percent of Total Services, 1983	Percent Change 1981-83	Percent of Total Services, 1983
Skilled Nursing	114%	45.1%	118%	30.0%	40%	42.1%
Physical Therapy	174	12.6	115	19.8	60	11.4
Speech Therapy	72	2.3	111	1.9	30	1.2
Occupational Therapy	146	2.9	1,186	1.0	119	1.7
Medical Social Services	371	1.6	486	0.5	184	1.0
Home Health Aide	134	35.5	97	46.7	88	42.5
All Services	129%	100.0%	109%	100.0%	62%	100.0%
NUMBER OF VISITS	1981	1983	1981	1983	1981	1983
Total	64,999	148,840	77,668	162,336	652,762	1,054,938
Per Person 65 and over	.47	1.02	.69	1.38	1.43	2.21

In some areas, such as Boston, historical factors may have caused VNAs to limit their markets to specific towns or communities within a metropolitan area. Similarly, hospital-based agencies may define their markets as patients being discharged from their own hospital. Proprietary agencies almost always define their market as the entire metropolitan area.

Less populated areas located near metropolitan areas (i.e., within 25 to 50 miles of the city) are sometimes served by branch offices of agencies in the metropolitan areas or by the agencies themselves.

Industrial Structure: Agency Type and Affiliation.

A major change has occurred in the distribution of agencies, by agency type. In 1972, the industry was dominated by government-operated agencies (57 percent) and VNAs (22 percent), while there were relatively few proprietary and private non-profit agencies (2 percent and 4 percent, respectively). By 1984, the relative importance of government and VNAs had declined (23 and 16 percent, respectively), while the number of proprietaries and private non-profits had grown substantially (30 and 15 percent, respectively). During this period hospital-based agencies also increased in relative importance (from 10 to 17 percent). Similar trends were observed in the number of Medicare beneficiaries served, although VNAs continued to serve the largest portion of beneficiaries.

Accompanying the growth in proprietaries has been growth in chain operated agencies. As of June 1984, the five largest home health care chains operated 339 Medicare-certified agencies.

The growth of proprietaries and private non-profit agencies has changed the nature of the home health care market. The home health care environment has changed in many localities from that of a single or small number of charitable, community supported, non-profit agencies providing services in a relatively non-competitive environment, to a highly competitive market, characterized by extensive marketing and aggressive agency behavior to solicit new business. In some areas, previously dominant VNAs have adopted competitive modes of behavior, such as aggressive marketing and joint ventures with hospitals, in order to retain their market shares.

An additional factor in the market has been the growth of hospital-based agencies, noted above. This has accompanied the corporate reorganization of many hospitals, the search for allied lines of business, and the introduction of DRGs. The continuing growth in hospital-based agencies may substantially change the nature of competition in the industry because of its tie to the principal home health referral source, the hospital discharge planner. We have seen several cases in the three market studies of hospital-based agencies being formed and very quickly securing most of the home health care business from patients discharged at their hospitals.

Industrial Structure: Market Concentration.

In each of the three market areas studied, metropolitan areas of 1 to 4 million persons, there were a relatively large number of home health agencies, ranging from 14 in Sacramento to 60 in Boston. The number of agencies is growing in each of the market areas, with no evidence that the number has stabilized.

Medicare home health market shares and market concentration data for each of the three market study sites are shown in Exhibit 5-2. Boston is dominated by VNA-type agencies while New Orleans is dominated by proprietary agencies. The Medicare market share of the single largest agency in 1983 ranged from 22 percent (New Orleans) to 60 percent (Sacramento). The combined market share of the largest five agencies ranged from 48 percent (Boston) to 95 percent (Sacramento). While the extent of market concentration may appear less in Boston than in the other sites, the VNAs in Boston have historically defined their market areas as a small portion of the metropolitan area. Within each of these areas, a VNA typically provides most of the home health services, in some areas as much as 95 percent of the services.

Over the last several years, there is evidence of reduced market concentration in local markets. In many areas, a single VNA, until recently, controlled most of the home health care market. This dominance is being challenged by proprietary and hospital-based agencies, and in some cases, by VNAs serving other

EXHIBIT 5-2

MEDICARE HOME HEALTH MARKET SHARE
AT THE THREE MARKET STUDY SITES, 1983

SACRAMENTO		NEW ORLEANS		BOSTON	
Agency Type	Percent of Total Charges	Agency Type	Percent of Total Charges	Agency Type	Percent of Total Charges
VNA	60%	Proprietary	21%	VNA	28%
Proprietary	17	Proprietary	12	VNA	7
Proprietary	10	Proprietary	15	VNA	5
Proprietary	5	Proprietary	11	VNA	4
Proprietary	3	Hospital-based	10	VNA	4
5 largest agencies	95%		69%		48%
Number of Medicare certified agencies	9		14		48
Medicare charges - all agencies	$6,663,000		$7,555,000		$35,870,000
Medicare charges - Per person 65 and over	$64.21		$64.21		$75.30

portions of the metropolitan area. In two of the three markets studied, the share of Medicare revenue and visits of the dominant area agency, a VNA, had declined over the past few years. In New Orleans, no Medicare-certified VNA exists.

Total Medicare home health charges at each of the market study sites are shown in Exhibit 3-2, along with charges on a per person 65 and over basis. Total area expenditures in 1983 were $6.8 million in Sacramento and New Orleans and $3.6 million in Boston. On a per person 65 and over basis, total charges were initially identified in Sacramento and New Orleans at $64.21 and $64.22 respectively, and $75.30 in Boston. The difference in charges between Boston and the other market sites (17 percent) indicates differences in the quantity of home health visits (Exhibit 5-1) as charges per visits was considerably lower in Boston than in the other two sites.

Barriers to Entry.

One of the necessary conditions for a competitive market is the absence of significant barriers to entry of new firms. In the absence of relatively easy entry, the existing firm(s) may be able to protect their monopoly or oligopoly* position. Under the current system, barriers to entry in the home health care

*Oligopoly is where a small number of firms each has a sizeable share of the market.

industry are minimal. Capital requirements and start-up costs are low, and regulatory and licensure requirements are not excessively burdensome. Each of the three areas studied has been characterized by entry, and to a lesser extent by withdrawal, of a sizeable number of new agencies within the last two years.

Nature of Competition.

Competition among home health agencies is primarily for sources of referral, rather than for the consumer directly. For each of our market study areas, agencies reported that 60 to 80 percent of referrals came from the hospital discharge planners, with referrals by physicians and patients' families accounting for most of the remainder of new business. These findings were confirmed in a recent national study. While agencies continue to market directly to hospital discharge planners, agencies are increasingly marketing to physicians and to the general public directly.

Primary agency selection criteria used by hospital discharge planners are quality, range of services, experience, personal rapport with the agency staff, and availability of services on short notice. Some discharge planners also indicated that agency follow up, community presence and willingness to accept Medicaid and charity patients were also important.

Price appears to play little or no role in selection of an agency for Medicare, Medicaid, and even private patients, most of whom had private insurance coverage for home health care. It was reported that price can be important for self-pay patients and patients covered by HMOs, with whom agencies may contract to provide services. However, these patients tend to account for less than 5 percent of most agencies' business, even in areas with strong HMO presence. Prices charged private patients are usually identical to each agency's Medicare reimbursement levels.

Agency Charge and Cost Patterns.

Discussions with home health agencies indicated that a significant portion seek to have their costs approximate Medicare payment limits. Excesses above limits are not reimbursed and amounts below limits represent "lost revenue". In fact, average charges tend to be very close to the Medicare limits for agencies in Sacramento and New Orleans. The exceptions tend to be new agencies, which frequently have high start-up costs and low volume. In Boston, costs for VNAs, which are the dominant agency type in the area, were significantly below Medicare limits. This may relate to a combination of several factors: low Medicaid payment rates which would not be subsidized by Medicare; cost subsidization by United Fund and other community and charitable sources of funds; substantial free care provided by the agencies; absence of profit maximizing behavior; and lower service costs due possibly to smaller geographic service areas served.

Agencies interviewed at the market study sites could not provide accurate information as to resource costs of providing home health care. However, we have developed the following general conclusions regarding home health care costs:

- direct labor costs (time spent traveling, providing services, documenting visits, following up with discharge planners, etc.) were the largest component of costs, representing 50 to 75 percent of agency costs;
- general overhead costs were the next largest component of costs; and
- costs tended not to vary substantially by size of agency, although in the short run, average overhead costs decline as volume expands.

In general, reported costs and charges are strongly influenced by Medicare cost limits and reimbursement regulations.

Reactions to Medicare and Medicaid.

Criticism of Medicare and Medicaid programs tended to relate to benefit restrictions, intermediary performance, agency administrative requirements and (for Medicaid) payment levels. The most frequently offered criticisms related to:

- excessively restrictive benefit rules: prevents provision of adequate care; results in retrospective denials for which agencies are not paid (Medicare and Medicaid);
- excessive paperwork and documentation required (Medicare and Medicaid);
- inconsistent administrative requirements and appropriateness of visit determinations among

intermediaries; some agencies search for more lenient intermediary (Medicare);

- excessive payment delays (Medicare and Medicaid); and
- inadequate levels of payment (Medicaid, primarily).

In assessing agency comments in regard to Medicare and Medicaid payment administration, it is important to understand that any system which seeks to limit payment rates and to prevent inappropriate utilization (as defined by law and implementing regulations) will engender complaints from providers. Some concerns can be addressed through the use of an alternative payment system approach, while others reflect the need to monitor program performance and to prevent inappropriate costs.

Reactions to Competitive Bidding.

Reactions to competitive bidding by agencies, hospital discharge planners, and others involved in the provision, payment or regulation of home health care, were mixed. Most expressed a concern for quality and adequacy of service under competitive bidding, fearing that length of visit or qualifications and skills of service delivery personnel may deteriorate. Concerns were expressed about monopoly situations developing or, at a

minimum, competition among agencies diminishing as most agencies are forced to close. Virtually everyone was opposed to Medicare contracting with a single agency to provide services to all beneficiaries in the area.

On the positive side, most agencies believed that program costs would be reduced (at least in the near term), and that departure from a cost reimbursement approach, with its perverse incentives and excessive paperwork requirements, would be beneficial. One proposal advanced by several agencies is replacement of cost reimbursement with a fee schedule that would be updated annually based on inflation experience. Others favored capitation-based payment, although details about how it would work and how payment rates would be determined were not specified.

5.3 Implications for Competitive Bidding

There are a number of important implications from this study of the home health market related to the feasibility and design of a competitive bidding system. They are stated briefly below.

1. Growing competitiveness of markets. Home health care agencies are becoming more numerous and more aggressively competitive. Competitive providers who

are actively seeking business are more likely to respond positively to and submit attractive bids than less competitive providers. The more competitive environment enhances prospects for success of competitive bidding.

2. Concerns about quality. The prospect of reduced quality was the major concern expressed about competitive bidding. Concerns were raised about price being the sole or primary selection criterion, of low bidders not being able to adequately provide increased volume of services, and of quality and patient visit time being reduced under the system. Clearly, assuring adequate levels of quality and service under the competitive bidding program needs to be a primary objective, both in designing and in administering the program.

3. Medicare accounts for most agency revenue. In the aggregate, Medicare accounts for 60 to 70 percent of home health agency revenue, with Medicaid accounting for much of the rest. If a sizeable share of agency revenue comes from private payors, HCFA could be less concerned about the impact of its system on the industry and on access to care of private patients. However, because of its dominance, HCFA does have to be concerned about the effects of its action on

possible growth of monopoly power, and on costs and access to use of others.

4. Medicare limits do not accurately reflect required resource costs of providing services. There are indications, based on cost variability among agencies and on comments received from agencies, that Medicare cost limits do not accurately reflect the necessary costs of efficiently providing different home health care services. This suggests that prices and relative bid prices among types of services under competitive bidding may be substantially different from that which exists under the current Medicare cost reimbursement system.

5. Cost reimbursement provides poor incentives and results in high administrative costs. Several agencies freely admitted that they (like others) seek, through cost allocation between allied businesses and adjustment of administrative costs, to achieve reported cost levels that are close to the Medicare limits in order to maximize revenue. In addition, many agencies complained about substantial administrative costs related to preparing and securing intermediary approval of cost reports. A simpler system embodying incentives for cost-effective provision of services, could result in substantial savings.

6. Substantial returns to scale do not exist. While most agencies could not accurately describe the relation between average visit cost and volume, most indicated that direct labor cost was the primary agency cost, and that fixed cost tended to be relatively low. Some economies may be achieved if increased volume reduces average travel time. However, cost reductions are not likely to be significantly different where a single agency provides all home health care in a metropolitan area or a small number of agencies (e.g., three to five) provide the care.

The implications from these market studies, particularly from the information received from the agencies themselves, suggests that substantial program savings could result under a well designed competitive bidding system. But serious, legitimate concerns exist about quality, adequacy of service and monopoly. They need to be seriously addressed in the design and administration of the systems.

APPENDIX A

HOME HEALTH AGENCIES

INTRODUCTION: Describe this project as a study of alternative payment mechanisms for home health care. Assure confidentiality of responses and let them know we need their help to develop an accurate profile of the market.

1) Definition of the Market

a. What services other than those required to obtain Medicare certification do you provide? Do you use any subcontractors to provide services? Which ones? Do you provide any services to other agencies by contract? Which services?

b. How do you define your market geographically? How many branch offices do you have? By services? By source of patients? Are there other factors that describe your market?

c. Who refers patients to you? What percent (roughly) of the time?

- Discharge Planners _____
- Physicians _____
- Skilled Nursing Facilities _____
- Other _____

d. What proportion of your patients are age 65 and older? _____

2) Characteristics of Agency

a. What is your annual number of visits? Please specify type;year.

e. What happens when Medicare/Medicaid benefits stop?

f. Have changes occurred as a result of recent Medicare/Medicaid program changes such as DRGs?

8) Likely Industry and Provider Reaction to Competitive Bidding Systems

Explain that we are studying several different payment alternatives, including competitive bidding. Use multiple winning bidder system with a few agencies selected on the basis of quality, service criteria and price.

a. Do you think such a competitive bidding by a major purchaser or third-party payor is a legitimate approach to paying for services?

b. What will be likely to happen under such a competitive bidding program to home health services? To prices? To the number of agencies in the area? What other effects may occur? To quality?

c. How do you think quality should be assessed?

d. What do you think is an appropriate unit on which price should be based?

e. Which types of agencies do you think will win contracts under a competitive bidding program?

f. Are there agencies that have the capacity to do all the Medicare work in the metropolitan area?

g. Will a competitive bidding system lower costs to Medicare and Medicaid? Which costs? How?

HOSPITAL-BASED AGENCIES

INTRODUCTION: Your agency is a unique type of agency. It is a hybrid: it is both a home health agency and a point of referral for home health. We would like to ask you questions about both these functions. Then, describe this project as a study of alternative payment mechanisms for home health care. We need their help in order to develop an accurate profile of the home health market.

A. Referral Source Questions

1. Please provide me with some information on your hospital. Describe service area, number of beds, specialties. Other unique characteristics.

_____

_____

_____

2. Do you refer to home health agencies other than your own? _____

_____

3. What do you believe to be most important in selecting home health agencies? Rate from most important to least important factors.

Reliability? _____

Quality? _____

Region served? _____

Advertising? _____

Price? _____

Personal relationship with agency staff? _____

Other? _____

4. Do you use the same home health agencies for private pay patients?

_____

_____

5. Any idea of annual number of home health patients which you refer?

6. Has the volume of home health referrals changed recently? In what way? Why?

7. Do certain agencies specialize in treating different types of patients? How does this affect your referrals?

8. Do you receive much advertising or other marketing techniques agencies? What do these techniques stress? Is price competition particularly intense?

9. Have you observed any relationships between price and quality of service?

B. Agency Questions

1) Definition of the Market

a. What services other than those required to obtain Medicare certification do you provide? Do you use any subcontractors to provide services? Which ones? Do you provide any services to other agencies by contract? Which services?

b. How do you define your market geographically? How many branch offices do you have? By services? By source of patients? Are there other factors that describe your market?

c. Do you accept referrals from outside of the hospital?

d. Who refers patients to you? What percent (roughly) of the time?

- Discharge Planners _____
- Physicians _____
- Skilled Nursing Facilities _____
- Other _____

e. What proportion of your patients are age 65 and older? _____

2) Characteristics of Agency

a. What is your annual number of visits? Please specify type;year.

b. What proportion of your services are provided by the following personnel?

Skilled nurses _____

Home health aides _____

Physical Therapists _____

Speech Therapists _____

Occupational Therapists _____

Medical Social Workers _____

c. What type of employment and payment arrangements do you have with your personnel? Salaried? Contract? Hourly? Visit?

_____

d. How would you classify your agency? VNA, local/state government, proprietary (franchise or chain), private nonprofit, hospital-based, other.

_____

_____

e. Is the agency affiliated with other non-home health businesses (e.g. owned by the same parent corporation, associated with a hospital or SNF)? List parent corporation.

_____

3) Cost of Home Health Services

a. Do you have any fluctuations in the number of clients served? Number of visits provided? Demand for certain services? How do you address these? Does your cost vary by volume? How?

_____

_____

_____

b. Could you estimate these major components of costs related to a skilled nursing visit?

Category	Average Cost per Visit
Personnel - Patient care time	
Travel time	
Administrative time	
Transportation - Mileage	
Medical supplies	
Pharmaceuticals	
Overhead - Building (dep. or rent)	
Utilities	
Maintenance	
General Administration/Clerical	

c. Are there any service categories for which payments are too low? too high?

d. Can you provide data on patient contact time?

d. Has the market changed within the past few years? If so, how and why?

e. What is your estimate of the proportion (or amount) of your business that is provided to Medicaid patients? To Medicare patients? To private pay patients?

5) Price Information

a. Request price lists.

b. Are prices different for services billed directly to patients than to third-party payors, such as Blue Cross, or Medicare or Medicaid? What are the payments received from each of the major payors (private insurance, self pay) per visit?

c. Do you specialize in treating certain types of patients?

6) Nature of Competition

a. What factors are most important in inducing referrals to a home health agency? Quality? Reliability? Referral Sources? Promotional advertising efforts? Region served?

b. How does your agency ensure quality services? What type of quality control programs do you participate in?

c. Does competition vary by size of community?

d. How important is price as a factor in competing for business? Does this differ for Medicare/Medicaid business and private business?

7) Medicare/Medicaid Barriers

a. Who is your intermediary?

b. What problems do you see with the current Medicare/Medicaid regulations and reimbursement practices?

c. Are these billing arrangements satisfactory to you? Do you have any difficulties with the following: payment levels, retrospective denials, reporting requirements, payment delays, claims processing errors?

d. If you could change the current Medicare and Medicaid payment systems, what changes would you suggest?

e. What happens when Medicare/Medicaid benefits stop?

f. Have changes occurred as a result of recent Medicare/Medicaid program changes such as DRGs?

8) Likely Industry and Provider Reaction to Competitive Bidding Systems

Explain that we are studying several different payment alternatives, including competitive bidding. Use multiple winning bidder system with a few agencies selected on the basis of quality, service criteria and price.

a. Do you think such a competitive bidding by a major purchaser or third-party payor is a legitimate approach to paying for services?

b. What will be likely to happen under such a competitive bidding program to home health services? To prices? To the number of agencies in the area? What other effects may occur? To quality?

c. How do you think quality should be assessed?

d. What do you think is an appropriate unit on which price should be based?

e. Which types of agencies do you think will win contracts under a competitive bidding program?

f. Are there agencies that have the capacity to do all the Medicare work in the metropolitan area?

g. Will a competitive bidding system lower costs to Medicare and Medicaid? Which costs? How?

REFERRAL SOURCES
(Discharge Coordinators)

INTRODUCTION: Describe this project as a study of alternative payment mechanisms for home health care. We need their help in order to develop an accurate profile of the home health market.

1. Please provide me with some information on your hospital. Describe service area, number of beds, specialties. Other unique characteristics.

2. How many home health agencies do you refer to? _____

3. On what basis do you select home health agencies? Rate from most important to least important factors.

   Reliability? _____

   Quality? _____

   Region served? _____

   Advertising? _____

   Price? _____

   Personal relationship with agency staff? _____

   Other? _____

4. Do you use the same home health agencies for private pay patients?

5. Any idea of annual number of home health patients which you refer?

6. Has the volume of home health referrals changed recently? In what way? Why?

7. Do certain agencies specialize in treating different types of patients? How does this affect your referrals?

8. Is there any crossover between home health services and hospital services? How does this affect your referrals?

9. Do you receive much advertising or other marketing techniques to entice you to change agencies? What do these techniques stress? Is price competition particularly intense?

10. Have you observed any relationships between price and quality of service?

11. Have recent Medicare/Medicaid program changes (such as DRGs) affected the number of home health referrals?

Explain that we are studying several payment alternatives, including competitive bidding. Explain multiple winning bidder system based on quality, services and price.

12. Do you think competitive bidding by a major purchaser or third-party payor is a legitimate approach to paying for service?

13. What will likely happen under a competitive bidding program to home health services? To prices? To the number of agencies in the area? What other effects may occur?

14. Which type of agencies do you think will win contracts under a competitive bidding program?

15. Will a competitive bidding system lower costs to Medicare and Medicaid?

16. Will it be more difficult for non-winning bidders to compete for private patient business?

PURCHASERS OF HOME HEALTH
(Third-party payors)

INTRODUCTION: Describe this project as a study of alternative payment mechanisms for home health care, including competitive bidding. Say that we need their help to develop an accurate profile of the market.

1. What benefits do you provide for home health? (Private and Medicaid)

1a. For Medicaid: Are you participating in the 2176 waiver program? What services are provided under that?

2. What has been the demand for this benefit? (Private)

3. Do you have any knowledge of the market for home health services in the (metropolitan) area?

VNA?

Local or state government?

Private non-profit?

Proprietary?

Hospital-based agencies?

SNF-based agencies?

4. Are there a few agencies having dominant market positions? What types of agencies?

5. Are there agencies that specialize in or accept only private pay patients?

6. How many visits were paid for last year? How many were billed?

7. What were the revenues for home health care last year, i.e., total amount paid for home health care?

8. What was the average cost per visit?

9. Do you have any breakdown available on the types of services used, by number of visits and/or number of patients, last year?

10. Is there substantial price competition among home health agencies? How concerned are buyers about price?

11. Do you have any information on the range of prices paid for common home health services? Obtain the range of payments for specific visit types as a list.

12. How are your rates set? What are your payments based on?

13. Have changes occurred as a result of recent Medicare/Medicaid program changes such as DRGs?

14. What problems exist now in home health payment mechanisms/Medicare/Medicaid purchase? What changes would you recommend?

15. Do you think competitive bidding by a major purchaser or third-party payor is a legitimate approach to paying for home health services?

16. What will likely happen under a competitive bidding program to home health services? To prices? To the number of agencies in the area? What other effects may occur? To quality?

17. Which type of agencies do you think will win contracts under a competitive bidding program?

18. Do you think certain costs to you or to home health agencies can be substantially reduced under a competitive bidding system for Medicare/Medicaid home health services? For whom?

19. Will it be more difficult for non-winning bidders to compete for private patient business?

MEDICAID REPRESENTATIVE ONLY

Regulatory environment:

Medicaid reimbursement rates (obtain from Q12):

Based on Medicare Schedule? _____

Percentage of charges? _____

Rates from some other fixed schedule? _____

Lowest charge level limitation on certain services? _____

Agency's customary charge for visit? _____

Prevailing charge in area for visit? _____

Billing problems:

STATE GOVERNMENT HEALTH REGULATORY OFFICIALS

INTRODUCTION: Describe this project as a study of alternative payment mechanisms for home health care, including competitive bidding. We need their help to develop an accurate profile of the home health market.

1. Can a home health agency in your state be licensed without also being Medicare-certified?

2. Does your state have its own regulations for home health agencies, different from federal regulations?

licensure

personnel qualifications

clinical record review

quality assurance

How are these enforced?

Are they tied to Medicaid or Medicare reimbursement rules?

Are there any advertising restrictions?

Are there any state laws pertaining to costs of home health services?

3. Do state regulations favor any particular type of agency? If yes, how?

4. Does your state have Certificate of Need for home health agencies?

5. Do you have any sense of the market for home health services in your state? Which are the dominant agencies? Do you have any feel for their market shares?

VNA?

Local government?

Private nonprofit?

Proprietary?

Hospital-based agencies?

SNF-based agencies?

6. Are there state-sponsored home health agencies? Do they compete with other types of agencies? Who do they serve? What portion of all services do they perform?